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BEFORE THE  
OREGON MEDICAL BOARD  
STATE OF OREGON

IN THE MATTER OF: )  
 ) **FINAL ORDER**  
**STEVEN ARTHUR LATULIPPE, MD** )  
**LICENSE NO. MD22341** )

**HISTORY OF THE CASE**

On December 4, 2020, the Oregon Medical Board (Board) issued an Order of Emergency Suspension of License and Notice of Opportunity for Hearing to Steven Arthur LaTulippe, MD (Licensee), ordering the immediate suspension of Licensee's license to practice medicine in Oregon and ordering that he immediately stop practicing medicine until further order of the Board. On January 5, 2021, Licensee, through counsel, requested a contested case hearing. On January 11, 2021, the Board referred the matter to the Office of Administrative Hearings (OAH).

On January 20, 2021, Presiding Administrative Law Judge Monica A. Whitaker of the OAH held a telephone prehearing conference. Attorneys Robert Tyler and R. Todd Frahm appeared for Licensee. Senior Assistant Attorneys General Warren Foote and Katharine DiSalle appeared for the Board. The following persons were also present for the Board: Executive Director Nicole Krishnaswami; Interim Chief Investigator Walter Frazier; Administrative Specialist Michele Sherwood; Executive Support Specialist Laura Mazzucco; and Medical Director David Farris, MD. A hearing was scheduled, via video conference, with Senior Administrative Law Judge (ALJ) Jennifer H. Rackstraw for February 16 through 22, 2021, and a deadline was set for the submission of exhibits and witness lists.

On February 9, 2021, ALJ Rackstraw held a video conference via WebEx to discuss hearing logistics related to the video conference format. Attorney Mariah Gondeiro appeared for Licensee. Mr. Foote and Ms. DiSalle appeared for the Board. Also present for the Board were Dr. Farris, Mr. Frazier, Ms. Sherwood, Ms. Mazzucco, Board Investigator Jason Carruth, and Board employee Gretchen Kingham. Court Reporter Monica DeLong was also present.

On February 10, 2021, the Board requested that the OAH schedule a prehearing conference to discuss Licensee's forthcoming request to reset the hearing due to a family matter involving Licensee's lead attorney, Mr. Tyler. The OAH scheduled such a conference for February 12, 2021, and on that date, ALJ Rackstraw held a telephone prehearing conference. Attorney Kristina Heuser appeared for Licensee. Mr. Foote appeared for the Board. Also present for the Board were Dr. Farris, Ms. Sherwood, and Ms. Mazzucco. ALJ Rackstraw granted the unopposed request to reset the hearing and the parties agreed to new hearing dates of March 15 through 19, 2021.

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1 On February 22, 2021, the Board filed a Motion for Qualified Protective Order and a  
2 proposed "Qualified Protective Order Limiting Use and Disclosure." On February 26, 2021,  
3 Licensee, through counsel, filed an Opposition to Motion for Protective Order and Cross-Motion  
4 for Discovery. On March 2, 2021, the Board filed a Response to Opposition to Motion for  
5 Qualified Protective Order and Response to Cross-Motion for Discovery. On March 12, 2021,  
6 ALJ Rackstraw issued a Ruling on Motion for Protective Order and Qualified Protective Order,  
7 as well as a Ruling Denying Cross-Motion for Discovery.  
8

9 On March 15, 16, 17, 18, 19, and 24, 2021, a hearing occurred via video conference, with  
10 ALJ Rackstraw presiding. Ms. Heuser represented Licensee. Mr. Foote represented the Board.  
11 Court Reporter LeeAnne McAdam was present and subsequently provided a written transcript of  
12 the proceedings. Tammy Clark was present for certain portions of the hearing on Licensee's  
13 behalf. The following witnesses provided testimony: Licensee; Dr. Farris; Dr. Melissa Sutton;  
14 Dr. Dawn Nolt; Board Investigator Carruth; Kathryn Ellis-Kelemen; Marina Bednarowski;  
15 Robert Berry; Cameron Miles; Margaret Murphy; Teresa LaTulippe; Dr. Thomas Stern; and  
16 Kristen Kelly. The evidentiary record closed on March 24, 2021.<sup>1</sup>  
17

18 Between March 15 and 24, 2021, the Board provided Draft Transcripts for the six days of  
19 proceedings. On March 26, 2021, the parties filed their written closing arguments. On April 6,  
20 2021, the Board provided Second Draft Transcripts, along with Errata Sheets that noted minor  
21 corrections to the transcripts from March 15, 16, 18, and 19, 2021.<sup>2</sup>  
22

23 The Board adopts the History of the Case, Issues, Evidentiary Ruling, Findings of Fact  
24 and Conclusions of Law and Order contained in the Proposed order in their entirety, except for  
25 modifications provided herein and identified via footnotes. The Board also makes minor  
26 modifications to reflect that it, and not the Administrative Law Judge, is issuing the order.  
27

28 On April 21, 2021, ALJ Rackstraw issued a Proposed Order, recommending the Board  
29 find that Licensee's continued practice of medicine constitutes an immediate danger to the public  
30 and a serious danger to the public health or safety. The Proposed Order also recommended that  
31 the Board confirm its December 4, 2020 Order of Emergency Suspension of Licensee's medical  
32 License.<sup>3</sup>  
33

34 On May 1, 2021, Licensee submitted written exceptions to the Proposed Order. The  
35 Board has reviewed and considered these exceptions to the extent they did not attempt to  
36 introduce new evidence, and finds they are without merit.  
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42 <sup>1</sup> Pursuant to OAR 137-003-0560(4), at the January 20, 2021 prehearing conference, the parties agreed to  
43 extend the deadline for issuance of the Proposed Order from 15 days to 20 business days, given the  
44 anticipated duration and potential complexity of the hearing. See OAR 137-003-0560(3)(b).

45 <sup>2</sup> The transcript citations herein refer to the Second Draft Transcripts (with the minor corrections), designated as  
46 follows: Transcript I: March 15, 2021; Transcript II: March 16, 2021; Transcript III: March 17, 2021; Transcript  
IV: March 18, 2021; Transcript V: March 19, 2021; and Transcript VI: March 24, 2021.

<sup>3</sup> We modify the Proposed Order's History section to include this new information.

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## ISSUES

1. Whether Licensee's continued practice of medicine constitutes an immediate danger to the public or a serious danger to the public health or safety. ORS 183.430(2); ORS 677.205(3); and OAR 137-003-0560(1) and (7).<sup>4</sup>

2. Whether circumstances at the time of the issuance of this final order<sup>5</sup> justify confirmation, alteration, or revocation of the Board's December 4, 2020 Order of Emergency Suspension of License. OAR 137-003-0560(7) and OAR 137-003-0655.<sup>6</sup>

## EVIDENTIARY RULINGS

Licensee's Exhibits R1 through R115 were admitted into the record without objection.

The Board offered Exhibits A1 through A25. Exhibits A1, A4 through A13, A15 through A19, A21, A22, and A24 were admitted into the record without objection. Exhibits A2, A3, A14, A20, A23, and A25 were admitted over Licensee's various objections.

Pleadings P1 through P25 were also made a part of the record.

## FINDINGS OF FACT

### Licensee's Relevant Background

1. After high school, Licensee enlisted in the U.S. Air Force. He thereafter obtained a Bachelor of Science degree in Biology from Boise State University (Boise State). While pursuing his undergraduate degree, he was active in the Idaho Air National Guard. He also attended Boise Bible College and Cincinnati Bible Seminary. He subsequently entered a Ph.D. program in Microbiology at the University of Massachusetts at Amherst, where he had a teaching assistantship and taught general microbiology and pathogenic bacteriology. He left the Ph.D. program (prior to obtaining the advanced degree) to begin an aviation career in the U.S. Air Force, where he became a commissioned officer. (Tr. III at 7-9; Tr. V at 82-83.)

2. In 1997, Licensee received his Medical Degree from Loma Linda University School of Medicine, where he co-taught medical microbiology. He completed an internship and residency in the Family Medicine Program at Wheeling Hospital in Wheeling, West Virginia. He received extensive training in rural family medicine, as well as training in surgical obstetrics, dermatology, intensive care, psychiatry, and the performance of upper and lower endoscopies. (Tr. III at 9-10; Tr. V at 83; *see* Ex. A1 at 1-2.)

3. In April 2000, Licensee obtained his Oregon medical license and started a Family Medicine practice, South View Medical Arts (the clinic), in Dallas, Oregon. (Tr. I at 84, Tr. III

<sup>4</sup> We modify the administrative rules cited to reflect those that apply to a final order, rather than a proposed order.

<sup>5</sup> We modify this phrase to reflect the now-relevant date.

<sup>6</sup> *See* footnote 4.

1 at 11; *see* Exs. A1 at 1, A2 at 4.) Shortly thereafter, he joined the Oregon National Guard, where  
2 he served as a Medical Review Officer, Chief of Pharmacy, and Chief of Medicine. (Tr. III at  
3 11.)  
4

5 4. Dallas is a small quasi-rural community located approximately 20 to 25 minutes from  
6 Salem. The geographic area is underserved with regard to Psychiatry, Pain Medicine, and  
7 Addiction Medicine. For the past decade, Licensee has spent approximately 50 percent of his  
8 time practicing Pain Medicine and Addiction medicine. The remainder of his practice consists of  
9 providing full-spectrum care to all ages, from newborn to geriatric patients. (Tr. I at 42, 84; Tr.  
10 III at 12-14.) He is approved as a supervising physician, and he has trained multiple physician  
11 assistants at the clinic. (Tr. I at 47; Tr. III at 17; *see* Exs. A1 at 5, A2 at 4.)  
12

13 5. Licensee is board certified in Family Medicine. (Tr. III at 11-12; Ex. A1 at 1-2.) He  
14 has lectured on the topics of Pain Medicine and Addiction Medicine in Southern Oregon and  
15 Oregon's Willamette Valley, and he has published an article regarding central pain.<sup>7</sup> (Tr. III at  
16 11.) He previously held clinical privileges at Salem Hospital and the North Bend Surgery  
17 Center, where he performed minor surgeries and endoscopies. (Tr. I at 43, 48; Tr. 3 at 14; Tr. V  
18 at 83-85; *see also* Ex. A1 at 6-8.)  
19

20 6. Excluding complaints related to the current matter, the Board has received 11  
21 complaints regarding Licensee. All but two of those 11 complaints closed without any Board  
22 action. One complaint closed in 2009, after the Board issued a Letter of Concern to Licensee  
23 regarding his treatment of a 17-year-old patient who he had diagnosed with bi-polar disorder.  
24 One complaint, pertaining to an allegation of failing to adhere to prescribing guidelines, is still in  
25 the investigatory process. (*See* Exs. A1 at 3, A2 at 4.)  
26

### 27 **COVID-19 Pandemic**

28

29 7. SARS-CoV-2 is a coronavirus that causes COVID-19, an infectious disease.<sup>8</sup> (Tr. I at  
30 120, 122.)  
31

32 8. On February 28, 2020, the Oregon Health Authority (OHA) confirmed Oregon's first  
33 presumptive case of COVID-19. (Ex. A16 at 1; Tr. I at 147.) On March 8, 2020, Oregon  
34 Governor Kate Brown declared a state of emergency pursuant to ORS 401.165. (*See Elkhorn*  
35 *Baptist Church v. Brown*, 366 Or 506, 512 (2020) (discussing Governor Brown's issuance of  
36 Executive Order No. 2020-03 on March 8, 2020).) On March 11, 2020, the World Health  
37 Organization (WHO) declared the COVID-19 outbreak a global pandemic. (Tr. I at 122.)  
38

39 9. The Centers for Disease Control and Prevention (CDC) estimates that 4.9 percent of  
40 all COVID-19 infections have resulted in hospitalization. Between March 1 and May 2, 2020,  
41  
42

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43 <sup>7</sup> During his hearing testimony, Dr. LaTulippe did not specify the name of the article or the publication in which it  
44 appeared, and the remainder of the record is silent on those facts.

45 <sup>8</sup> At hearing, the terms "COVID-19" and "COVID" were sometimes used by hearing participants (myself included)  
46 as a catch-all for the SARS-CoV-2 virus and the COVID-19 disease or pandemic. Unless expressly stated herein,  
we make no relevant distinction between the uses of those terms in the record.

1 17 percent of all patients hospitalized for COVID-19 died. That figure has improved over time,  
2 but in-hospital mortality for COVID-19 remains higher than for influenza. (Tr. I at 159.)  
3

4 10. On May 9, 2020, the OHA issued an update to its “Clinical Care, and Healthcare  
5 Prevention and Control Guidance for COVID-19” recommending universal source control (*i.e.*,  
6 masking) for both patients and providers in all healthcare settings and advising that healthcare  
7 providers wear a face covering or face mask at all times while in a healthcare facility, unless  
8 alone in a private office.<sup>9</sup> (Tr. I at 115-116, 186, 190-191.)  
9

10 11. Effective June 5, 2020, Governor Brown issued Executive Order No. 20-27, which  
11 states, in part:  
12

13 2. [P]ursuant to ORS 401.168(1), ORS 401.175(3), ORS 401.188(2) to (3),  
14 and ORS 433.441(3):  
15

16 \* \* \* \* \*

17  
18 b. Individuals must comply with any public health directives set forth in  
19 my Executive Orders.  
20

21 c. Individuals should maintain physical distancing of at least six feet from  
22 any person who is not a member of their household, when possible, and  
23 should adhere to any applicable Oregon Health Authority (OHA)  
24 guidance, including but not limited to guidance on physical distancing and  
25 face coverings. OHA guidance is available at  
26 <https://govstatus.egov.com/OR-OHA-COVID-19>.  
27

28 \* \* \* \* \*

29  
30 9. Guidance. At my direction, and under the authority of this and other  
31 Executive Orders, OHA and other appropriate agencies have issued and  
32 will continue to issue and revise detailed guidance for the public, for  
33 employers, and for particular sectors of the economy[.]  
34

35 \* \* \* \* \*

36  
37 25. Legal Effect. This Executive Order is issued under the authority  
38 conferred to the Governor by ORS 401.165 to 401.236. Pursuant to ORS  
39 401.192(1), the directives set forth in this Executive Order shall have the  
40 full force and effect of law, and any existing laws, ordinances, rules and  
41 orders shall be inoperative to the extent they are inconsistent with this  
42 exercise of the Governor’s emergency powers.  
43  
44  
45

46 <sup>9</sup> The OHA created the first version of its “Clinical Care, and Healthcare Prevention and Control Guidance for COVID-19” in March 2020. (Tr. I at 186.)

1 26. Enforcement. The directives in this Executive Order and any guidance  
2 issued by OHA or other state agencies to implement this Executive Order  
3 are effective statewide, unless otherwise specified. This Executive Order  
4 and any guidance issued by OHA to implement this Executive Order are  
5 public health laws, as defined in ORS 431A.005, and may be enforced as  
6 permitted under ORS 431A.010. In addition to any other penalty that may  
7 be imposed under applicable laws, any person, business, or entity found to  
8 be in violation of this Executive Order or any guidance issued by OHA or  
9 other state agencies to implement this Executive Order is subject to the  
10 penalties described in ORS 401.990.

11  
12 (Oregon Executive Order No. 20-27.)<sup>10</sup>  
13

14 12. On June 9, 2020, the CDC issued updated guidance for healthcare facilities, titled  
15 “Healthcare Facilities: Managing Operations During the COVID-19 Pandemic” (June 9, 2020  
16 Guidance). (See Ex. A10 at 1-5.) The CDC noted in the June 9, 2020 Guidance that previous  
17 guidance “was preventative and meant to help healthcare facilities prepare for community  
18 transmission, while current guidance is for managing operations during the pandemic.” (*Id.* at  
19 1.) The June 9, 2020 Guidance recommended that healthcare systems adjust their standard  
20 delivery approaches to reduce the need for in-person care by optimizing the use of telehealth and  
21 managing mildly ill patients at home. (*Id.* at 2-3.) To prevent the transmission of COVID-19 by  
22 COVID-19 infected persons who may or may not be showing symptoms, the June 9, 2020  
23 Guidance recommended that healthcare facilities use source control for all persons (e.g., staff,  
24 patients, and visitors) who enter a healthcare facility. The June 9, 2020 Guidance specified that  
25 cloth masks are considered source control (and not personal protective equipment (PPE)), and  
26 while cloth masks may be appropriate for patients and visitors, healthcare personnel should wear  
27 PPE. (*Id.* at 3.)  
28

29 13. On July 22, 2020, after receiving citizen complaints alleging that some providers  
30 were not masking in healthcare settings,<sup>11</sup> the OHA issued a stand-alone document making clear  
31 that all healthcare personnel were required to wear masks at all times in all healthcare settings,  
32 unless they were alone in a private office. (Tr. I at 116-118, 182-184.) Also on July 22, 2020,  
33 the OHA updated its “Statewide Mask, Face Covering, Face Shield Guidance for Health Care  
34 Offices” (July 22, 2020 OHA Guidance). The July 22, 2020 OHA Guidance states, in pertinent  
35 part:  
36

37 **Authority:** Executive Order No. 20-27, paragraphs 9 and 21, ORS  
38 433.441, ORS 433.443, ORS 431A.010  
39

40 **Applicability:** This guidance applies statewide to:  
41

42 <sup>10</sup> Pursuant to ORS 183.450(4) and OAR 137-003-0615(1), the ALJ takes notice of this executive order, available  
43 online at <[https://www.oregon.gov/gov/Documents/executive\\_orders/eo\\_20-27.pdf](https://www.oregon.gov/gov/Documents/executive_orders/eo_20-27.pdf)>. Any party objecting to such  
44 notice was authorized to file an objection with the ALJ no later than three days after the issuance of the Proposed  
45 Order. No party filed an objection.

46 <sup>11</sup> At hearing, Dr. Sutton estimated that the OHA had received between 10 and 20 such complaints throughout  
Oregon. (Tr. I at 118-119.) She opined that, despite those complaints, by July 2020, “almost all healthcare  
providers were masking at all times in all healthcare settings” in Oregon. (*See id.*)

1  
2 All health care personnel in health care offices, as defined below.  
3

4 All patients and visitors in health care offices, as defined below.  
5

6 **Enforcement:** To the extent this guidance requires compliance with  
7 certain provisions, it is enforceable as specified in Executive Order 20-27,  
8 paragraph 26.  
9

10 \* \* \* \* \*

11  
12 **For purposes of this guidance the following definitions apply:**  
13

14 ● “Face covering” means a cloth, polypropylene, paper or other face  
15 covering that covers the nose and the mouth and that rests snugly above  
16 the nose, below the mouth, and on the sides of the face.  
17

18 ● “Face mask” means a medical grade mask.  
19

20 ● “Face shield” means a clear plastic shield that covers the forehead,  
21 extends below the chin, and wraps around the sides of the face.  
22

23 ● “Healthcare Personnel (HCP)” means all paid and unpaid persons  
24 serving in healthcare offices who have the potential for direct or indirect  
25 exposure to patients or infectious materials \* \* \*. HCP include, but are not  
26 limited to, nurses, nursing assistants, physicians, \* \* \*, and persons not  
27 directly involved in patient care, but who could be exposed to infectious  
28 agents that can be transmitted in the healthcare setting (e.g., clerical \* \* \*).  
29

30 ● “Health care office” means \* \* \* [a]ny non-licensed medical, dental, or  
31 other health care office where health care is provided to patients, including  
32 but not limited to primary care offices, specialty care offices, \* \* \*, and  
33 urgent care settings.  
34

35 \* \* \* \* \*

36  
37 ● “Physical Distancing” means maintaining a space of 6 feet or more in all  
38 directions between individuals.  
39

40 \* \* \* \* \*

41  
42 **Health care offices are required to:**  
43

44 ● Have policies and enforce policies that require all individuals who enter  
45 the health care office to wear a face mask, face covering or face shield  
46

1 while inside, including when in a private examination room, except as  
2 follows:

3  
4 ■ If a patient cannot tolerate any form of face mask, face  
5 covering or face shield due to a medical condition, strict physical  
6 distancing must be observed until the patient can be placed or  
7 roomed in an area that minimizes risk to others.

8  
9 ■ A face mask, face covering or face shield is not required to be  
10 worn during an examination or procedure in which access to  
11 parts of the face that are covered by a face mask, face covering  
12 or face shield is necessary. A face mask, face covering or face  
13 shield is required to be worn as soon as the examination or  
14 procedure in question has completed.

15  
16 ● Have policies and enforce policies that require HCP to wear appropriate  
17 personal protective equipment (PPE) for the care of patients with  
18 suspected COVID-19, confirmed COVID-19, or a known exposure to  
19 COVID-19 (See “PPE for Healthcare Personnel” Section).

20  
21 \* \* \* \* \*

22  
23 **Health care personnel are required to:**

24  
25 ● Wear a face mask or face covering that covers the nose and mouth at all  
26 times while in the health care office, except when in a private office by  
27 themselves.

28  
29 ■ Face masks should be prioritized over face coverings because  
30 they offer both source control and protection for the HCP from  
31 potentially infectious droplets, splashes, or sprays.

32  
33 ■ Cloth face coverings may not be worn instead of a respirator or  
34 face mask if more than source control is needed.

35  
36 \* \* \* \* \*

37  
38 ■ Face shields should be worn in addition to, but not in place of,  
39 face masks for the purposes of eye protection and additional  
40 layer of splash protection.

41  
42 ■ Face masks or face coverings are not required while eating or  
43 drinking, but strict physical distancing should be maintained  
44 while face masks, face shields, or face covering are not worn.



- 1           ● Wear N95 masks or higher-level respiratory protection instead of a face  
2 covering or face masks for patient care that warrants a higher level of  
3 protection (See “PPE for Healthcare Personnel” Section).  
4

5                               \* \* \* \* \*

6  
7           **All patients and visitors when visiting a health care office are required**  
8 **to:**  
9

- 10          ● Wear a face mask, face covering, or face shield unless the individual is  
11 under five (5) years of age, except as follows:  
12

13               ■ Face masks, face shields or face coverings are not required  
14 while eating or drinking, but strict physical distancing (6 feet or  
15 more) should be maintained while face masks, face shields, or  
16 face covering are not worn.  
17

18               ■ A face mask, face covering or face shield is not required to be  
19 worn during an examination or procedure where access to parts  
20 of the face that are covered by a face mask, face covering or face  
21 shield is necessary. A face mask, face covering or face shield is  
22 required to be worn as soon as the examination or procedure in  
23 question has completed.  
24

25               ■ Face masks, face shields or face coverings can be briefly  
26 removed in situations where identity needs to be confirmed by  
27 visual comparison. If possible, limit speaking while the cover is  
28 off as speaking generates aerosols and droplets that can contain  
29 viruses.  
30

31                               \* \* \* \* \*

32  
33           Use of a face shield alone should be limited to situations when  
34 wearing a face mask or face covering is not feasible in the  
35 following situations:  
36

37               ◆ When a person has a medical condition that prevents them  
38 from wearing a face mask or face covering.  
39

40               ◆ When people need to see mouth and tongue motions in order  
41 to communicate (e.g., teachers of children in certain  
42 developmental stages or when communicating with people with  
43 hearing impairments).  
44

45           Notify a health care office or their HCP in advance of an office visit if the  
46 individual has a medical condition that makes it hard to breathe or a

1 disability that prevents them from wearing a face mask, face shield or face  
2 covering, so that appropriate accommodations can be made that ensure the  
3 safety of other patients and visitors, and HCPs.  
4

5 (Ex. A23 at 1-4; bold emphasis in original.)  
6

### 7 **Licensee's Clinic Practices**

8

9 14. For at least the last two years, Emily Miles worked as the clinic's receptionist, and  
10 Mrs. LaTulippe, Licensee's wife, worked as Licensee's medical assistant and office manager.  
11 (Tr. I at 47-48; Tr. II at 236; Tr. III at 16-17.) Ms. Miles had no formal medical training.<sup>12</sup> (Tr.  
12 V at 127.)  
13

14 15. Prior to the COVID-19 pandemic, the clinic maintained a seasonal cold and flu  
15 protocol that included heightened sanitation standards. (Tr. I at 53; Tr. III at 41; Tr. V at 52.)  
16 The clinic also had an air ventilation system that filtered and recirculated air at least every hour.  
17 (Tr. V at 123-124.) After COVID-19 was declared a pandemic, Licensee added the following to  
18 his typical cold and flu season clinic protocols: social distancing of patients in the waiting room  
19 (*i.e.*, six-foot rule); taking patients to examination rooms quickly; trafficking patients through the  
20 clinic in designated directions so they would not cross paths with one another; placing hand  
21 sanitizer at the receptionist window and in the common area behind the receptionist for  
22 patient/visitor use;<sup>13</sup> scheduling patients with complaints of cough, congestion, fever, anosmia,  
23 and/or other symptoms suggestive of viral illness either at the end of the workday or during the  
24 lunch hour when no other patients were present at the clinic; taking such patients immediately to  
25 an examination room; and increasing the clinic's already heightened cold and flu season  
26 sanitation procedures. (Tr. I at 53-54, 60-62; Tr. III at 45-48, 91; Tr. V at 37-38, 51-52, 122,  
27 125, 128.)  
28

29 16. The clinic's written "Coronavirus Protocol" states:  
30

- 31 1. Direct to ED—all patients with severe presumptive COVID symptoms:  
32 fever, chough [sic], muscle aches, chest tightness/pain, shortness of breath.  
33  
34 2. Keep distance of 6 feet between all patients.  
35  
36 3. Minimize contact between and with patients.  
37  
38 4. One-way entry and exit for all patients.  
39  
40 5. Only one patient per room.  
41  
42 6. Don a mask on any patient with a cough, fever, or any suspicious viral  
43 illness.  
44

45 <sup>12</sup> The record is silent as to whether Mrs. LaTulippe has any formal medical training.

46 <sup>13</sup> At hearing, Licensee clarified that the sanitizer was present and made available to patients year-round, but that he  
and clinic staff actively encouraged patients to use it during cold and flu season. (*See* Tr. III at 46-47.)

7. Thoroughly sanitize exam room after each patient leaves room.
8. Those who refuse to come in, schedule back in 2 weeks.
9. Provide refills to next follow-up visit.
10. Patients and staff wash hands before and after each patient contact.

(Ex. A5 at 10.)

17. Clinic staff conducted an initial screening of patients for COVID-19 illness when a patient first called the clinic to make an appointment. Mrs. LaTulippe would conduct a “telephone triage” and ask questions about the patient’s symptomology and course of illness. (See Tr. V at 45.) The clinic’s COVID-19 screening protocol did not include calling patients prior to their regularly scheduled appointments to screen for potential COVID-19 symptoms. Licensee instead relied upon “common sense” and expected that if a patient with a regularly scheduled appointment was “significantly sick,” the patient would call prior to their appointment to report such illness. (*Id.* at 46.) Licensee’s COVID-19 screening protocols did not include taking temperatures on all patients who presented at the clinic. (Tr. I at 60; Tr. III at 43-44.) Licensee’s COVID-19 screening protocols did not include asking patients if they had been in close contact with any person who had COVID-19 symptoms or who had tested positive for COVID-19. (Tr. V at 47-49.)

18. As of approximately March 2020, when a patient arrived at the clinic for a routine scheduled appointment, Licensee relied upon Ms. Miles to assess whether the patient had symptoms suggestive of COVID-19. (Tr. V at 46-47.) Licensee had trained Ms. Miles “to look at [the patient] and just take a look at them and see if they look sick,” and, if the patient was “smiling and happy,” Ms. Miles was instructed to ask how the patient was feeling. (*Id.* at 46-47.) If the patient indicated that they “felt fine” and they were “not ill,” Ms. Miles would direct the patient to sit in the waiting area (maintaining social distance) until Mrs. LaTulippe led them to an examination room. (Tr. I at 60.) If Ms. Miles made a visual determination that a patient looked sick, or the patient indicated that they had symptoms of COVID-19 or they were not feeling well, the patient was immediately taken to a designated examination room. (Tr. V at 47.)

19. When performing invasive surgical procedures on patients, whether at the clinic (or historically at a surgical center), consistent with standard protocol for surgical suites, Licensee wore a surgical mask. (Tr. I at 43-44, 75-76.) However, in Licensee’s opinion, “there is no medical evidence that proves that masks are even of benefit during surgery.” (*Id.* at 45.)

20. Absent surgical procedures, Licensee did not wear a mask when treating patients at the clinic between March 2020 and December 2020. Licensee did not require patients or clinic visitors to wear masks during that time period, unless they were “acutely ill, coughing, [or]

///

1 congested,” or otherwise had signs suggestive of respiratory illness.<sup>14</sup> (Tr. I at 50-52, 54, 60-61;  
2 Tr. V at 19-20.) Licensee estimates that at least 95 percent of his patients chose not to wear a  
3 mask while at his clinic. (Tr. IV at 90.) Licensee has never demanded that a patient remove  
4 their mask at the clinic. (Tr. I at 55.) Mrs. LaTulippe and Ms. Miles did not wear masks at the  
5 clinic between March 2020 and December 2020.<sup>15</sup> (See Tr. V at 19, 160.)  
6

7 21. Licensee acknowledges that a person does not have to be coughing to pass  
8 respiratory droplets infected with SARS-CoV-2 to other persons, and he acknowledges that  
9 masks can capture large respiratory droplets. However, he believes that masks do not capture  
10 small respiratory droplets and aerosols, and that respiratory aerosols account for approximately  
11 80 percent of SARS-CoV-2 transmission.<sup>16</sup> (Tr. V at 95.) Because Licensee believes masking  
12 does not protect a wearer from aerosols, when treating a COVID-19 infected patient at the clinic  
13 in 2020, Licensee never wore a mask. But because Licensee was “concerned” about his  
14 exposure to such patients, he employed other, non-masking measures, which he considered  
15 “survival tactics,” while treating the patients. (See *id.* at 36-41.)  
16

17 22. For example, on one occasion, Licensee treated a male patient who had developed  
18 “SARS-CoV-2 full-blown syndrome.” (Tr. V at 36-37.) The patient was “coughing like crazy,”  
19 he had nausea, severe muscle aches and fever; and he complained of feeling as though he was  
20 going to die. (*Id.* at 36-38.) Licensee had the patient don a mask “to just make any attempt to  
21 decrease his exposure as he was coughing as I am directly in front of his face examining him.”  
22 (*Id.* at 38, 120.)  
23

24 23. After an initial evaluation of the patient, Licensee thought to himself, “[O]kay, this is  
25 the day that I’m going to contract Coronavirus illness myself. And so my precautions were to  
26 use my so-called survival tactics.” (Tr. V at 37; see also *id.* at 38.<sup>17</sup>) Licensee left the door to  
27 the examination room open during the entire patient encounter and, while taking the patient’s  
28 history, Licensee maintained a distance of approximately nine to ten feet from the patient (and  
29 the patient’s wife, who had accompanied him and was displaying milder symptoms of COVID-  
30 19). (*Id.* at 38-39, 116.) Licensee is a swimmer and has good respiratory endurance. (*Id.* at 39.)  
31 During the multiple instances where Licensee had close physical contact with the patient—to  
32 listen to his heart, lungs, and bowels; to examine his nasal cavity, oral cavity, and ears; and to  
33 perform other routine checks—Licensee held his breath, and then released his breath once he  
34 was again nine to ten feet away from the patient. Licensee had the patient remove his mask  
35  
36

37  
38 <sup>14</sup> At hearing, Licensee explained that he asked patients with symptoms of respiratory illness — such as chest  
39 tightness, cough, fever, shortness of breath — to wear a mask “[f]or the large respiratory droplets,” even though he  
40 did not believe that the mask made any significant difference. (Tr. I at 61-62; Tr. V at 35.)

41 <sup>15</sup> At hearing, Licensee testified that Ms. Miles was “very highly intolerant of mask wearing. She would get severe  
42 panic attacks. She would develop headaches, and \* \* \* she ha[d] \* \* \* a three- to four-foot distance between  
43 patients and her sitting position at the window, and I deemed that to be adequate.” (Tr. I at 61.)

44 <sup>16</sup> At hearing, Licensee testified that the medical literature supports that aerosols constitute the  
45 predominant mode of COVID-19 transmission. (Tr. V at 10, 109.)

46 <sup>17</sup> At hearing, Licensee testified that as the patient was profusely coughing, Licensee thought, “[O]kay, this is going  
to be my day that I get infected.” (Tr. V at 38.) And then Licensee testified, “[A]nd I had other days like that.”  
(*Id.*)

1 during certain portions of the physical examination, and then put the mask immediately back on.  
2 (See *id.* at 39-41, 112-113, 119-120.)  
3

4 24. Licensee has never been tested for COVID-19 and he has “never manifested any  
5 COVID-19 symptoms,” but he “would not be at all surprised if [he] tested positive for IgG,  
6 which is the long-term exposure antibody suggesting prior infection at some time.” (Tr. V at 36,  
7 41, 121, 135, 143.<sup>18</sup>)  
8

9 25. It was Mrs. LaTulippe’s responsibility to bring patients with known or presumed  
10 COVID-19 from the waiting room to an examination room, where she was then in close contact  
11 with the patients while taking their temperature, blood pressure, and other vitals. Licensee  
12 informed Mrs. LaTulippe that she was at risk in caring for such patients and he urged her to take  
13 “all precautions.” (Tr. V at 128-130.) “All precautions” did not include Mrs. LaTulippe wearing  
14 a mask.<sup>19</sup> (See *id.* at 19.) After Licensee treated a patient with COVID-19 symptoms, such as  
15 the male patient previously described, Mrs. LaTulippe would sanitize the room and make sure it  
16 was not used for other patients for some period of time “to allow \* \* \* for any miniscule  
17 respiratory droplets to settle and for the air to recycle again.” (*Id.* at 41.)  
18

19 26. In Licensee’s opinion, there are studies showing “absolutely no benefit when  
20 comparing an N95 respirator to a cloth mask or to a surgical mask, \* \* \* [and] that the infectivity  
21 rate was completely identical, [and] in other words, the masks, regardless of material, made no  
22 difference whatsoever.” (Tr. I at 80.) In Licensee’s opinion, masks have been “proven  
23 scientifically not to be a barrier to the spread of aerosols.” (Tr. IV at 88.) In Licensee’s opinion,  
24 universal masking is contributing to an increase in the spread of COVID-19. (Tr. I at 101.)  
25 Licensee believes there are increased COVID-19 infection rates “in the areas or regions of our  
26 country where there is increased masking and good compliance.” (*Id.* at 80-81.) Licensee  
27 believes there are “at least 17 well-designed randomized controlled trials that eliminated any  
28 question about masks being effective, and they were shown to be of no effect whatsoever.” (*Id.*  
29 at 82; Tr. III at 26, 28-29.) In Licensee’s opinion, there is “no medical evidence to substantiate  
30 wearing a mask to protect yourself” from COVID-19; there is “not a single randomized  
31 controlled study that shows any benefit to wearing a mask to prevent COVID transmission;”  
32 there are “fairly conclusive studies [pertaining to influenza] that showed no benefit to wearing a  
33 mask as a source of reducing \* \* \* upper respiratory viral disease transmission;” and mask-  
34 wearing may cause harm to the wearer, particularly if the wearer is elderly or has comorbidities  
35 such as emphysema.<sup>20</sup> (Tr. I at 56-58, 86; Tr. V at 30, 32.) Licensee was open and candid with  
36

37 <sup>18</sup> At hearing, Licensee testified that “there is a very good chance that I have been infected with SARS-CoV-2 \* \* \*  
38 [because] I was exposed to some very sick patients and a good number of them.” (Tr. V at 143.)

39 <sup>19</sup> Licensee testified at hearing that Mrs. LaTulippe cannot “tolerate wearing a mask,” and he explained that after  
40 flying while masked on two occasions, she was left wheezing and exhausted. (See Tr. V at 19.) The record also  
41 demonstrates, more likely than not, that Ms. LaTulippe shares Licensee’s views regarding masking harms and  
42 ineffectiveness. (See, e.g., Tr. I at 126, 141-142; Tr. II at 146-150, 155-156; 237-238, 244; Tr. V at 170.)

43 <sup>20</sup> At hearing, Licensee testified that in 2020, he treated “a significant number of comorbidities directly  
44 associated with the mask wearing,” including depression, panic/anxiety, fatigue, headache, confusion,  
45 lightheadedness, impetigo, parotitis, and conjunctivitis. (Tr. I at 58, 89-92; Tr. V at 33; see also Tr. IV at  
46 84.) He testified that when he treated a patient with symptoms that he determined were caused by  
increased CO2 levels in the body because of mask wearing, he “absolutely” communicated to the patient  
that masking was responsible for the harm they experienced. (Tr. V at 33.)

1 his patients and the public at large regarding his views on masking harm and ineffectiveness.  
2 (See, e.g., Tr. I at 54-58, 62-64; Tr. IV at 104; Tr. V at 21-24, 27-29, 59-60; Exs. A3 at 3, A5 at  
3 3.)  
4

5 27. In Licensee's opinion, the body's natural immune system is a more effective defense  
6 against COVID-19 than a mask, even an N95 mask. Licensee believes that entities such as the  
7 CDC and the OHA have not issued guidance on the issue of immune defense because such  
8 entities have "an alternative agenda" that is "comprised primarily of money and power and  
9 politics and control of the population." (Tr. V at 142.) Licensee believes that government  
10 entities and agencies have "severely weaponized and politicized" COVID-19 guidelines for  
11 masking and other measures. (Tr. I at 56.) In Licensee's opinion, the Governor's COVID-19  
12 Executive Orders and associated OHA guidelines are "unscientific." (*Id.* at 87.)  
13

14 28. From March to December 2020, Licensee engaged in an informed consent process  
15 with each patient "to establish whether or not they should be wearing a mask," based on his  
16 opinions of the medical evidence pertaining to mask-wearing (as detailed in the findings  
17 above).<sup>21</sup> (Tr. I at 54-58; Tr. IV at 104; Tr. V at 21-22.) Licensee routinely directed patients to  
18 watch a YouTube video titled, "Tammy K. Herrera Clark on Face Mask Effectiveness." (Tr. I at  
19 62-64; Tr. V at 23-24, 27; see Exs. A5 at 3, A6 at 1.) He made available to patients a small  
20 paper document advertising Ms. Clark's YouTube video, which stated:  
21

22 SCIENTIFIC MASK FACTS  
23 YouTube Video  
24

25 "Tammy K. Herrera Clark  
26 On  
27 Face Mask Effectiveness"  
28

29 (Only the truth will make you free)  
30

31 (See Ex. A5 at 3, 9; Tr. V at 23, 27-29.) Ms. Clark's positions on masking are congruent with  
32 Licensee's belief that the sum of the medical evidence shows that masks are not an effective  
33 barrier for reducing the transmission of respiratory disease. Licensee believes that Ms. Clark is a  
34  
35  
36

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37 <sup>21</sup> At hearing, Licensee provided the following example:  
38

39 So when I would discuss the risks and benefits, I had \* \* \* elderly people with  
40 comorbidities such as emphysema, asthma or just debilitated because of advanced age \* \*  
41 \*, and they would be in a panic saying I can't breathe with this mask on.

42 So, what did I tell them? I said \* \* \* take off the mask, you are harming yourself. And  
43 again, I would reaffirm, what does the medical evidence show? No benefit."  
44

45 (Tr. I at 58; see also *id.* at 64.) Licensee also testified that he would inform a patient that wearing a mask could cause  
46 them harm "by increasing the body's carbon dioxide content" if he felt such information was relevant to that patient.  
(Tr. V at 32.)

1 credible authority on the effectiveness (or ineffectiveness) of mask wearing to reduce the  
2 transmission of disease.<sup>22</sup> (Tr. I at 63-64; *see* Tr. V at 23-24.)  
3

4 29. In Licensee's opinion, he has been "a strong asset to the public in educating them on  
5 the real facts about this pandemic, and likewise \* \* \* none of my patients were placed in  
6 immediate danger. I would say that at least \* \* \* 98 percent of my patients were so extremely  
7 thankful that I did not wear a mask or demand wearing a mask in my clinic[.] They did not  
8 perceive an immediate danger." (Tr. V at 59-60.)  
9

10 30. In Mrs. LaTulippe's opinion, masked elderly patients were "usually distressed" and  
11 had difficulty breathing when presenting at the clinic. (Tr. II at 244.) Ms. LaTulippe routinely  
12 told those patients they could remove their masks.<sup>23</sup> (*See id.* at 244, 237-238.)  
13

14 31. In approximately late February or early March 2020, a letter carrier with the U.S.  
15 Postal Service who was assigned to deliver mail to the clinic questioned Ms. Miles as to why  
16 clinic staff did not wear masks. In response, Ms. Miles informed the letter carrier that masks did  
17 not work and she provided him with a link to a website that discussed the dangers of masking.  
18 At some later date, while again delivering mail to the clinic, the letter carrier engaged in a heated  
19 exchange with Ms. Miles and/or Licensee regarding the clinic's position on masking. Thereafter,  
20 the mail carrier requested that the Postmaster alter his route so that he would no longer be  
21 required to deliver mail to the clinic. Dr. LaTulippe and/or clinic staff also filed a complaint  
22 regarding the mail carrier with the Postmaster. (Tr. II at 155-174, 241-242.)  
23

24 32. In approximately May or June 2020, Licensee informed a patient who was  
25 experiencing elevated blood pressure that wearing a mask might be contributing to her condition.  
26 (Tr. V at 168, 172-173; Tr. VI at 20-21.) Licensee also told the same patient that she was at  
27 greater risk from CO2 toxicity from mask wearing than she was from getting COVID-19. (Tr. V  
28 at 170-171.) On at least one occasion, Mrs. LaTulippe told that patient that COVID-19 was no  
29 different than a cold and that the flu was more hazardous. (*Id.* at 170.)  
30

31 33. On June 8, 2020, Mrs. LaTulippe immediately directed an elderly patient, DE, to  
32 remove her mask when DE presented for her examination. Mrs. LaTulippe then told DE and  
33 DE's adult daughter who had accompanied her to the appointment, Ms. Ellis-Kelemen, that the  
34 mask would cause CO2 issues and compromise DE's breathing. A short time later, while  
35 observing that Ms. Ellis-Kelemen continued to wear her mask during the appointment, Mrs.  
36 LaTulippe made a comment such as "Oh, you're one of those people."<sup>24</sup> (Tr. I at 126-127, 141-  
37 142.)  
38

39 <sup>22</sup> Exhibit R92 identifies Ms. Clark as having 20 years of experience as an "Environmental Health and Safety  
40 Compliance Specialist." (*See* Ex. R92 at 4.) She did not testify at the hearing, and her qualifications as an expert on  
41 masking effectiveness were not otherwise established in the record.

42 <sup>23</sup> At hearing, Mrs. LaTulippe testified, "[A] lot of these elderly people come in having so much trouble  
43 breathing with those masks that when I take them back \* \* \* to get weighed, I let them know that they  
44 have permission to take it off if they would choose to, if they would like to, if they are having trouble  
45 breathing." (Tr. II at 237-238.)

46 <sup>24</sup> At hearing, Mrs. LaTulippe denied directing DE to remove her mask on June 8, 2020, and she denied  
making a comment to Ms. Ellis-Kelemen along the lines of, "Oh, you're one of those people." (*See* Tr. II

1  
2 34. In July 2020, a patient who had previously established care with Licensee called the  
3 clinic to seek medical advice following a potential COVID-19 exposure. Mrs. LaTulippe spoke  
4 with the patient, who reported that she had recently been camping with friends, outdoors and  
5 unmasked. Upon hearing that the patient was not experiencing any symptoms of COVID-19,  
6 Mrs. LaTulippe informed the patient that she did not need to get a COVID-19 test, that she did  
7 not need to isolate, that being exposed to other people would provide immunities from COVID-  
8 19, and that masks are ineffective for reducing the spread of COVID-19. The patient was  
9 concerned about the advice she received from Mrs. LaTulippe, so she called the clinic again the  
10 following day, with the hope of obtaining medical advice from someone different. The patient  
11 again spoke with Mrs. LaTulippe, who reiterated that masks do not work. Mrs. LaTulippe also  
12 directed the patient to a YouTube video from Tammy K. Herrera Clark, titled "Destroying the  
13 Mask Narrative." (Tr. II at 146-150, 155-156.) One or two days later, the patient again called  
14 the clinic, with the goal of learning the full name and credentials of the woman (*i.e.*, Mrs.  
15 LaTulippe) with whom she had spoken on the previous occasions. The patient was again routed  
16 to speak with Mrs. LaTulippe, who appeared displeased with the patient's request for identifying  
17 information. (*Id.* at 150.) A few days later, the patient received a letter from the clinic, stating  
18  
19

20 at 237-238.) Given the conflict in the record over these matters, it is necessary to assess the credibility of  
21 Mrs. LaTulippe and Ms. Ellis-Kelemen.  
22

23 While a witness is presumed to speak the truth, the presumption may be overcome "by the manner in  
24 which the witness testifies, by the character of the testimony of the witness, or by evidence affecting the  
25 character or motives of the witness, or by contradictory evidence." ORS 44.370. A determination of  
26 witness credibility may also be based on the inherent probability of the evidence, whether the evidence is  
27 corroborated, whether the evidence is contradicted by other testimony or evidence, whether there are  
28 internal inconsistencies, and "whether human experience demonstrates that the evidence is logically  
29 incredible." *Tew v. DMV*, 179 Or App 443, 449 (2002), citing *Lewis and Clark College v. Bureau of*  
30 *Labor*, 43 Or App 245, 256 (1979) *rev den* 288 Or 667 (1980) (Richardson, J., concurring in part,  
31 dissenting in part).

32 Given the various factors discussed above, Mrs. LaTulippe's denials regarding her alleged statements to  
33 DE and Ms. Ellis-Kelemen on June 8, 2020, are not persuasive. The cumulative evidence in the record  
34 demonstrates that Mrs. LaTulippe actively encouraged patients not to wear masks at the clinic, and that  
35 she readily communicated her strong opinions about the dangers and lack of efficacy of masking to clinic  
36 patients and visitors. Directing an elderly patient to remove her mask, espousing the dangers of masks to  
37 such patient, and making a negative remark to an accompanying person who insisted on remaining  
38 masked at the clinic appear consistent with Mrs. LaTulippe's fervent and freely expressed masking  
39 opinions. In addition, Mrs. LaTulippe has significant motive to minimize and mischaracterize her  
40 conduct in this proceeding, given the seriousness of the Board's action against her husband and the  
41 attendant consequences to their careers and livelihoods. Conversely, Ms. Ellis-Kelemen has no known  
42 motive to be untruthful in this matter. Moreover, her hearing testimony was sufficiently detailed, logical,  
43 and plausible. Overall, when weighed against the seemingly reliable testimony of Ms. Ellis-Kelemen,  
44 Mrs. LaTulippe's denials about her statements to DE and Ms. Ellis-Kelemen on June 8, 2020, are not  
45 persuasive. Furthermore, where Mrs. LaTulippe's testimony conflicts with other, more reliable evidence  
46 elsewhere in the record, the administrative law judge accorded greater weight to that other evidence. We  
agree.



1 that she was no longer a patient at the clinic and requesting that she, her household members, and  
2 any spouses or boyfriends do not call or visit the clinic.<sup>25</sup> (*Id.* at 150-151; *see* Ex. A24 at 1.)  
3

4 35. Although Licensee believes it is “theoretically possible” that an asymptomatic person  
5 infected with SARS-CoV-2 could transmit the virus to other persons by speaking and breathing,  
6 he believes that such an occurrence is unlikely. (Tr. V at 96.) In his opinion, asymptomatic  
7 spread has not been sufficiently demonstrated in the medical literature and is not a significant  
8 factor in the spread of COVID-19. (*Id.* at 9, 49; *see also* Tr. I at 103-104.)  
9

10 36. Licensee believes that approximately 75 patients he treated at the clinic in late  
11 October 2019, early November 2019, late January 2020, and early February 2020 had COVID-  
12 19. (Tr. I at 68-69; Tr. III at 19, 51-52; Tr. V at 85, 97-98, 101-104.) Between late November  
13 2020 and early December 2020, Licensee treated approximately 125 patients with COVID-19 in  
14 the clinic.<sup>26</sup> (*See* Tr. I at 70; Tr. III at 53; Tr. V at 99, 106-107.)  
15

16 37. Licensee did not recommend masking to any COVID-19 infected patients he treated  
17 in 2020. Rather, he recommended isolation, distancing, avoiding contact with shared objects and  
18 people, and increased frequency of hand washing. (Tr. V at 107-109, 111.)  
19

20 38. Licensee did not perform COVID-19 testing at the clinic. The patients he treated  
21 with confirmed COVID-19 infections were tested elsewhere. (*See* Tr. III at 53; Tr. V at 106-  
22 107.) Licensee believes that the widely-used PCR test for COVID-19 detection has resulted in a  
23 “tremendous amount of false positives.” (Tr. I at 104, 106-107.) Licensee is not aware of any  
24 person who contracted COVID-19 from his clinic. (*Id.* at 98.) The Board is not aware of, nor  
25 has it identified, any person who contracted COVID-19 from visiting Licensee’s clinic. (Tr. II at  
26 121.)  
27

28  
29 <sup>25</sup> The letter to the patient is dated July 23, 2020 and states, in relevant part:

30 Due to recent issues of conflict regarding medical care and I believe that a  
31 congenial patient-doctor relationship is critical to good care. And due to resent  
32 phone call stating that you were no longer a patient here. I feel it would be in our  
33 mutual best interest to terminate your services effective immediately, as a patient  
34 at South View Medical Arts. We ask that you do not call or show up at our  
35 office, as of now you are no longer a patient, this includes spouse as well. We  
36 will cancel all appointments. We wish you the best of care and good health in  
37 your future.

38 Best regards,  
39 Office management/Personal  
40

41 CC Includes all family/household members/and spouses/boyfriends/etc  
42

43 (Ex. A24 at 1; letter appears in its original form, with no grammatical or spelling corrections.)  
44

45 <sup>26</sup> At hearing, Licensee testified that between February 10, 2020 and late November 2020, not a single patient  
46 presented at his clinic with symptoms of respiratory illness. (*See* Tr. I at 65-68, 70, 85; Tr. III at 52-53; Tr. V at 99,  
106.) Licensee further testified that no clinic staff ever worked while ill (or while having a cough, fever, or other  
respiratory symptoms). (Tr. I at 68.)

1  
2                   **Board Investigation**  
3

4           39. Beginning in July 2020, the Board received four complaints regarding Licensee and  
5 his alleged failure to comply with masking mandates at the clinic. (*See* Ex. A3 at 1-4; A2 at 1, 4-  
6 5, 7; A1 at 4; Tr. I at 223, 237-238.) On July 16, 2020, the Board opened an investigation into  
7 the complaints and assigned Board Investigator Jason Carruth to the case. (Ex. A2 at 1; Tr. I at  
8 223, 239.)  
9

10           40. In a letter dated August 13, 2020, Investigator Carruth notified Licensee of the  
11 Board's investigation and summarized the allegations against Licensee as follows:  
12

13                   It is alleged that Licensee is not following social-distancing guidelines in  
14 his practice and care of patients. It is also alleged that Licensee is  
15 advising patients and the public that masks required under the current  
16 guidelines do not work and should not be worn. It is further alleged that  
17 Licensee has been posting to social media statements discouraging citizens  
18 from adhering to distancing guidelines specific to COVID-19.  
19

20           (Ex. A5 at 1; Tr. I at 223, 240.) In the letter, Investigator Carruth requested that Licensee  
21 respond to the allegations in detail, describe his adherence to social distancing guidelines in the  
22 practice setting, explain why he has encouraged "non-compliance with a government order to  
23 limit the spread of COVID-19," provide documentary support for his position that "masks and  
24 social distancing are not effective preventive measures," and answer specific questions relating  
25 to his experience, practice sites, and any privileges he holds. (Ex. A5 at 1.)  
26

27           41. On September 3, 2020, the Board received Licensee's response to Investigator  
28 Carruth's letter, consisting of a letter from Licensee dated August 31, 2020, nine attachments,  
29 and an attestation page addressing the specific questions posed by Investigator Carruth regarding  
30 Licensee's experience, practice sites, and privileges. (*See* Ex. A5 at 2-11; Tr. I at 223, 240.) In  
31 his August 31, 2020 letter, Licensee denied posting statements to social media that discourage  
32 citizens from adhering to COVID-19 social distancing guidelines, and he denied not following  
33 social distancing guidelines in his practice and care of patients, stating, "I have followed  
34 reasonable social distancing guidelines. I also implemented my standard clinic cold/flu season  
35 protocol that has served me very well for over 20 years." (Ex. A5 at 2.) In the same letter, he  
36 admitted to advising patients and the public that masks required under the current COVID-19  
37 guidelines are ineffective and should not be worn, specifically confirming, "As a medical  
38 professional with a former background in microbiology, I stand firm on this assertion." (*Id.*)  
39 Licensee's letter also states, in part:  
40

41                   I have a sign conspicuously posted in my office waiting room stating that  
42 our office is following a COVID-19 protocol, and I solicit cooperation.  
43 Furthermore, I have this protocol typed out in detail and posted at the  
44 receptionist and nurse stations. \* \* \*. We have strictly followed our  
45 protocol, and it has worked very well. We have had good patient  
46 cooperation, not a single problem related to any COVID, influenza or

1 other viral infections, despite my clinic having never closed throughout  
2 the entire cold/flu season. Incidentally, the very last presumed COVID  
3 case I treated was in early February. I treated perhaps 75 cases, and all  
4 fully recovered without sequelae. I have seen no viral upper respiratory  
5 infections in my clinic since that time.

6  
7 \* \* \* \* \*

8  
9 [I] have extensively educated myself on the characteristics of various  
10 mask types, their efficacy, utility, limitations, [and] associated risks of  
11 physical and psychological harm. My conclusion is that the mask affords  
12 minimal or no protection against viral upper respiratory infections. \* \* \*.  
13 The best N-95 mask has a mask filtration diameter of 0.3 micrometers  
14 (microns), and coronavirus has a diameter of 0.125 microns. Thus even  
15 the most highly filtering N-95 mask is incapable of filtering out the  
16 coronavirus. It is a worthless viral barrier, even if you assume the unlikely  
17 event that the mask has a perfect seal over the face. Furthermore, the  
18 lifespan of this mask is only *twenty minutes*.

19  
20 Few people are actually wearing an N-95 mask, and of these, many fewer  
21 wear it properly. None replace the mask every 20 minutes. The rest of the  
22 population who actually comply with this “government order” are wearing  
23 either paper masks or home-made cloth masks, having the efficacy  
24 comparable to putting up a chain-link fence to keep mosquitoes out of the  
25 yard. Are these masks providing any viral protection? Most definitely  
26 not. A fishnet stocking mask would be as effective as any paper or cloth  
27 mask—completely worthless. Add to this the fact that most people wear  
28 the masks improperly, and the declaration of being “worthless” degrades  
29 to the status of ridiculous. \* \* \*. Does wearing a mask have any scientific  
30 validity as a viral barrier to respiratory infection? Absolutely not. The  
31 claim that it may reduce the spread of respiratory droplets is irrelevant to  
32 real-life scenarios. People are rarely close enough to be contaminated by  
33 spit or bronchial secretions from a cough. And virtually every mask  
34 wearer is perfectly healthy. If one *is* acutely ill, they should stay home  
35 and convalesce until no longer infectious. The mask is worthless as a viral  
36 barrier.

37  
38 [I] share with you a 50-minute YouTube video presentation by a career  
39 PPE expert who actually trains OSHA personnel. The title is “Tammy K.  
40 Herrera Clark on Face Mask Effectiveness.” This is an excellent and  
41 thorough presentation that expounds on the real science of PPE. Finding  
42 no flaws in her presentation, I tested it further. \* \* \*. This is the  
43 information I have been disseminating to my patients and to the public.  
44 Several of my most staunch pro-mask patients, after watching it, actually  
45 called me back and apologized for harassing me about masks[.]  
46

1 [N]ot only is the mask completely worthless, but it also is very dangerous.  
2 Remember, I have not seen a single viral upper respiratory infection in my  
3 clinic since early February 2020. Yet I have treated hundreds of mask-  
4 related problems in my clinic since people have started wearing masks.  
5 What medical problems do[es] a mask directly *cause*? The morbidity is  
6 extensive. We have an abundance of well-documented cases of COPD  
7 and asthma exacerbations, heart attacks, stroke, collapsed lungs (even in  
8 youth), migraine headaches, facial impetigo, nasal pustulosis,  
9 *Staphylococcus aureus* (including MRSA)[,] pneumonia, fainting, fatigue,  
10 shortness of breath, confusion, nausea, dizziness, claustrophobia, mild  
11 narcosis, tremor, elevated blood pressure (hypertension), panic attacks,  
12 anxiety, and other psychosocial manifestations. Both [the] elderly and  
13 children are particularly vulnerable to harm[.]

14  
15 I could present you with many facts, case-studies, empirical evidence, and  
16 other data to support my assertion that masks do not work, and should not  
17 be worn, but the data would overwhelm you. I cannot compromise my  
18 personal integrity, moral standards, or my reputation as a caring and  
19 competent physician, for the sake of perpetuating a lie[.]

20  
21 [I] have always promoted the common sense principles of reducing  
22 infection, and this does include social distancing. The practicality of  
23 social distancing remains elusive. \* \* \*. How effective is social  
24 distancing? I don't believe we will ever have the true answer to this  
25 question. But what I do see are the abundant discrepancies regarding  
26 social distancing. \* \* \*. Any physician who examines a patient, of  
27 necessity, violates the [social distancing] guideline. For this reason, some  
28 physicians still choose to "see" patients via telemedicine only. Is this  
29 good? No. I had to rescue a good number of my patients during the  
30 COVID season who would have died without my direct intervention.  
31 They were advised to *not* go to the emergency department, and were  
32 unable to make any contact (even leave a message) with their specialists.  
33 \* \* \*. We as physicians need to practice universal precautions, but  
34 physicians avoiding all contact with severely ill patients is, in my  
35 estimation, dereliction of duty, and may be pure cowardice.

36  
37 \* \* \* \* \*

38  
39 The [Board] cites allegations of "not following guidelines" and  
40 "noncompliance with a government order."

41  
42 What exactly is the purpose of guidelines? If a face mask is completely  
43 ineffective against disease transmission, but a state governor seeks to  
44 enforce such guidelines, should we just oblige her? What motive has Kate  
45 Brown in declaring such a mandate? Does she have authority to do so?  
46 And why do OSHA personnel violate their own guidelines (personal risk

1 assessment before wearing a mask, complete physical exam, long-standing  
2 respirator standards) in the process of being cogently compelled to  
3 arbitrarily enforce a governor's nonsensical, unlawful guidelines?  
4 Governor Kate Brown has no legal jurisdiction under Oregon State  
5 constitutional law to issue such an order. The state Executive Branch has  
6 jurisdiction to declare, in a state of emergency, a 30-day order to directly  
7 deal with a crisis. This 30-day window ended on April 7, 2020, if memory  
8 serves me correctly. This means that this "government order" is unlawful;  
9 and this is why it cannot be (and is not) enforced by police departments.  
10 Her action is that of Marxist totalitarianism. \* \* \*. [I]f a guideline is  
11 unlawful, has no medically-based validity, and is detrimental to personal  
12 health, I cannot accept such a guideline, mandate, order, regulation – or  
13 whatever other name you choose to assign it[.]

14  
15 (*Id.* at 3-5; italicized emphasis in original.)  
16

17 42. On November 5, 2020, the Board's Investigative Committee directed the Board's  
18 medical director to ascertain Licensee's implementation of, and adherence to, applicable  
19 COVID-19 guidelines at his clinic and to remind him of his professional responsibilities  
20 pertaining to such. (*See* Ex. A2 at 2, 4; Tr. I at 224, 240, 245; Tr. II at 19, 91-92, 97.)  
21

22 43. In a letter to Licensee dated November 9, 2020, Board Medical Director David  
23 Farris, MD, stated, in part:  
24

25 It has come to the attention of the [Board] that you may be in direct and  
26 active violation of current Governor Executive Orders, to include  
27 Executive Order 20-22 and 20-59. These Executive Orders specify that  
28 elective and non-urgent procedures across all care settings that utilize PPE  
29 are allowed, but only to the extent they comply with guidance or  
30 administrative rules issued by the Oregon Health Authority. These rules  
31 require all people to wear properly fitted facemasks when indoors in any  
32 care setting. Masking has been shown to significantly reduce the spread  
33 of the novel coronavirus responsible for the current worldwide pandemic.  
34

35 It is the expectation of the Board that you immediately comply not only  
36 with the legal mandate, but with practices and professional conduct  
37 appropriate to the standards of medical care expected for a licensed  
38 medical professional in the state of Oregon.  
39

40 The current standard of practice in a primary care setting includes, at a  
41 minimum, pre-appointment and pre-entry screening of all patients to  
42 identify those who are or may be infectious with SARS-CoV-2;  
43 appropriate sequestration of such patients; appropriate protection of all  
44 staff with PPE; and thorough cleaning of instruments and surfaces  
45 between patients. Care that you provide to your patients that is not  
46 consistent with the standards may be found to be negligent and may also

1 constitute unprofessional or dishonorable conduct in that it does or might  
2 constitute a danger to the health or safety of a patient or the public, and  
3 may be subject to administrative sanctions.  
4

5 (Ex. A4 at 1.)  
6

7 44. In a letter to Dr. Farris dated November 23, 2020 Licensee stated, in part:  
8

9 [I] wholeheartedly share your concern for patient safety in this trying time  
10 of the pandemic. \* \* \*. I am not a novice to virology, disease  
11 transmission or epidemiology[.]  
12

13 [M]y patients are my family and I would never do anything to compromise  
14 their health. \* \* \*. I strive to seek out the best medical principles and the  
15 best scientific evidence to promote whole person care. \* \* \*. Providing  
16 top quality care to my patients has been my life goal as a physician, and I  
17 cannot help but feel attacked without just cause. I do not see where I have  
18 failed my patients or the public in any way.  
19

20 In all my years of medical practice, I have strictly abided by universal  
21 precautions, and I have always maintained a rigid cold/flu season protocol  
22 that has served my patients, my staff, and the public very well. I do take  
23 the COVID-19 pandemic seriously and have proactively instituted an  
24 office "coronavirus protocol" that has minimized patient infection risk. I  
25 have had zero problems with infectivity. None of my office staff or  
26 patients have become infected throughout the entire pandemic timeframe,  
27 despite having never closed my office. I have treated about 75 COVID-19  
28 patients prior to mid-February 2020, and all recovered quickly and  
29 completely. None were hospitalized. Just last week I saw my first two  
30 COVID cases of this fall, and the day after starting treatment they were  
31 already greatly improved. Thus, both my office protocol and therapies  
32 have proven to be highly effective, designed to protect both my patients  
33 and the public.  
34

35 [I] shall continue to maintain high standards of proven infectious disease  
36 prevention in my medical practice, and I anticipate, as I have  
37 demonstrated with a past perfect record, having no problems whatsoever.  
38

39 (Ex. A5 at 12-13.)  
40

41 45. On December 2, 2020, Board Investigator Carruth made an unannounced visit to the  
42 clinic. As of that date, the Board had not yet received Licensee's November 23, 2020 letter.<sup>27</sup>  
43 (See Ex. A2 at 3-4; Tr. I at 224-225, 252-253.) As he entered the clinic, he observed no easily  
44 visible signage setting forth COVID-19 protocols or stating that masks or other measures were  
45

46 <sup>27</sup> Licensee provided Investigator Carruth a copy of his November 23, 2020 letter during the site visit on December 2, 2020. (Tr. I at 224-225.)

1 required. He observed no visible hand sanitizer available to patients and visitors, and he  
2 observed no obvious screening measures being implemented as patients entered the clinic. (Ex.  
3 A2 at 3; Tr. I at 226-230, 256-258.) Affixed to the exit door of the clinic, and visible as patients  
4 and visitors exited, Investigator Carruth observed three posted documents: one document stated  
5 that the clinic was adhering to COVID-19 protocols, but it did not specify any such protocols;<sup>28</sup>  
6 one document explained the symptoms of carbon dioxide toxicity;<sup>29</sup> and one document  
7 referenced a CDC guideline on COVID-19, with two sentences highlighted emphasizing that  
8 only people with comorbidities experience issues with COVID-19. (See Exs. A2 at 3, A6 at 3-4;  
9 Tr. I at 226, 256-258.)

10  
11 46. Ms. Miles, who was sitting behind a sliding glass window and not wearing a mask,  
12 slid open the glass window and greeted Investigator Carruth. He observed other individuals  
13 behind her, including one patient who was making a follow-up appointment, who were also not  
14 wearing masks. He noted that as patients (and accompanying individuals) came and went, the  
15 receptionist performed the same action of sliding the glass barrier open to speak to them with no  
16 mask in place. While sitting in the waiting room, prior to meeting with Licensee, Investigator  
17 Carruth observed six patients and accompanying individuals entering and exiting the clinic, as  
18 well as a UPS delivery person entering the clinic. None of the patients and accompanying  
19 individuals wore masks, and he never saw the receptionist wear a mask. (Ex. A2 at 3; Tr. I at  
20 227-229, 254.)

21  
22 47. Investigator Carruth subsequently met with Licensee in his private office, whereupon  
23 Licensee, who was not masked, greeted him with an extended hand. When Investigator Carruth  
24 declined a handshake, Licensee crossed his arms, smiled, and asked how Investigator Carruth felt  
25 about COVID-19 policies and protocols. Licensee told Investigator Carruth, who was masked,  
26 that he could remove his mask if he wanted. Licensee explained his opinion that the masking  
27 protocols were not based on science. He told Investigator Carruth that he and his staff do not  
28 wear masks, but that the clinic's strict sanitation protocols had successfully prevented any  
29 COVID-19 outbreaks in the clinic. He told Investigator Carruth that his patients are welcome to  
30 wear masks if they choose to do so, but he admitted that he takes the opportunity to educate them  
31 on the futility of doing so.<sup>30</sup> He told Investigator Carruth that he had treated more patients  
32 experiencing complications due to mask wearing than patients with COVID-19. Licensee stated  
33 that he had successfully treated approximately 75 patients who were COVID-19 positive, with  
34 none of those patients needing hospitalization. Licensee expressed that he had no intention of  
35 changing his practice with regard to not requiring masks in the clinic. Licensee also told  
36 Investigator Carruth that he had researched the Oregon Constitution and determined that  
37 Governor Brown's executive orders were not legal or enforceable. (Ex. A2 at 3; Tr. I at 230-  
38 232, 253.) In his subsequent investigative report, Investigator Carruth noted that Licensee was  
39

40 <sup>28</sup> The one-page document states: "Our office is following Corona Virus (COVID-19) protocol. We  
41 appreciate your cooperation and understanding during this confusing time." (Ex. A6 at 3.)

42 <sup>29</sup> The one-page document listed the following "main symptoms" of carbon dioxide toxicity: dimmed sight; reduced  
43 hearing; shortness of breath; tremor; sweating; increased heart rate and blood pressure; drowsiness; mild narcosis;  
44 dizziness, confusion, headache; and unconsciousness. (Ex. A6 at 4.)

45 <sup>30</sup> A preponderance of the evidence establishes that Licensee "educates" patients on the alleged futility and dangers  
46 associated with mask wearing (*i.e.*, provides informed consent on mask wearing) even when patients do not ask  
about mask wearing or they do not complain of adverse symptoms related to mask wearing. (See, *e.g.*, Tr. I at 54-  
58; Tr. IV at 104; Tr. V at 21-22.)

1 “very open about his disdain for Governor Brown and stated the mask mandate was part of a  
2 Marxist government[] plot to control the population in the same way that Germany had done in  
3 the 40s.” (Ex. A2 at 3.) Licensee stated an interest in meeting with the Board to discuss the  
4 masking issue, and he laughed when Investigator Carruth told him the Board was currently  
5 meeting remotely. Licensee told Investigator Carruth that he would not agree to meet remotely  
6 with the Board and that if he were to meet with the Board in person, he would not wear a mask.  
7 (*Id.* at 4.)  
8

9 48. On December 3, 2020, the Board’s Investigatory Committee referred the matter to  
10 the full Board for action. On that date, the full Board convened via conference call at 5:00 p.m.,  
11 and a majority of the members voted to issue an Order of Emergency Suspension to Licensee.  
12 (*See* Exs. A14 at 1-2, A2 at 2; Tr. I at 255-256.)  
13

14 49. On December 4, 2020, the Board issued an Order of Emergency Suspension of  
15 License and Notice of Opportunity for Hearing to Licensee (Emergency Suspension Order).  
16 (Pleading P1.) The Emergency Suspension Order states, in part:  
17

18 By order of the [Board], the license of [Licensee] to practice medicine is  
19 hereby suspended, effective December 3, 2020, at 5:15 p.m. Pacific Time.  
20 As of this date and time, Licensee must stop practicing medicine until  
21 further order of the Board.  
22

23 \* \* \* \* \*

24  
25 [T]his order is made pursuant to [ORS] 677.205(3), which authorizes the  
26 Board to temporarily suspend a license without a hearing when the Board  
27 has evidence that indicates that Licensee’s continued practice constitutes  
28 an immediate danger to the public, as well as ORS 183.430(2), in that the  
29 Board has found that Licensee’s continued practice of medicine by a  
30 physician presents a serious danger to the public health or safety.  
31

32 \* \* \* \* \*

### 33 *CONCLUSIONS OF LAW*

34

35 The Board finds Licensee’s continued practice constitutes an immediate  
36 danger to the public, and presents a serious danger to the public health and  
37 safety as follows:  
38

39 5.1 During the pandemic, patients will inevitably present to Licensee’s  
40 clinic with known, suspected, or occult infection with SARS-CoV-2; and  
41

42 5.2 Such patients present a clear and present health risk to other patients  
43 and staff;  
44

45 5.3 Licensee’s active discouragement of mask wearing by patients and  
46 elimination of mask wearing by staff and Licensee represent a failure to



1 take appropriate steps to reduce the risk of transmission, thereby posing an  
2 unnecessary and preventable risk to patients, staff, and Licensee; and  
3

4 5.4 Licensee's instruction and example to patients to shun masks actively  
5 promotes transmission of the virus within the extended community; and  
6

7 5.5 Licensee's advice to patients regarding the failure of masks to prevent  
8 viral transmission and potential harm due to masks, are counter to basic  
9 principles of epidemiology and physiology and undermine acceptability  
10 among Licensee's patients and the general populace of one of the primary  
11 measures known to significantly diminish viral transmission; and  
12

13 5.6 Licensee's OHP patients are assigned to physicians by OHP and, if  
14 assigned to Licensee, have limited ability to transfer their care to a  
15 different provider. These particularly vulnerable patients are, therefore,  
16 largely forced to endure Licensee's unsafe practices while his medical  
17 license remains active.  
18

19 (*Id.* at 1, 6-7.) After the Order of Emergency Suspension became public, the Board received  
20 additional complaints regarding Licensee's care of patients. (Ex. A2 at 2.)  
21

## 22 **Expert Opinions**

### 23 *A. Melissa Sutton, MD, MPH*

24  
25  
26 50. Dr. Sutton graduated from Ben-Gurion University's Medical School for International  
27 Health in 2011. In 2014, she completed a Family Medicine Residency at Group Health  
28 Cooperative. In 2016, she completed a Global Health Course in "Clinical Tropical, Migrant and  
29 Travel Medicine" through the CDC and the University of Minnesota. (Ex. A7 at 1; Tr. I at 112-  
30 113.) In 2017, she received a Certificate of Knowledge in Clinical Tropical Medicine &  
31 Travelers' Health from the American Society of Tropical Medicine & Hygiene. In 2019, she  
32 received a Master's of Public Health (MPH) Degree in Epidemiology from Harvard University.  
33 She is a Diplomate of the American Board of Family Medicine, and she is licensed as a  
34 physician in Oregon and Washington. (Ex. A7 at 1; Tr. I at 112-114.)  
35

36 51. During various time periods from October 2014 to March 2020, Dr. Sutton worked  
37 as an Attending Physician, providing primary and urgent care in the State of Washington. In  
38 2018, she was a Rose Traveling Fellow and Michael von Clemm Traveling Fellow in  
39 Epidemiology at Harvard University. From January to December 2018, she worked as a Health  
40 Research Consultant in Rwanda, providing project support for a complex randomized controlled  
41 trial family strengthening initiative, including sampling strategies, complex survey instrument  
42 review and implementation in low-resource settings, survey instrument piloting and rater  
43 reliability calculations, data monitoring, and data collection reporting. In Rwanda, she also  
44 served as Co-Director of an International Dispensary, providing primary and urgent care,  
45 assisting with medical evacuations, conducting tropical medicine and immunization  
46

///

1 consultations, and functioning as a liaison to several local embassies and consulates. (Ex. A7 at  
2 2-3, 5.)  
3

4 52. Since February 2020, Dr. Sutton has worked as the Medical Director of Respiratory  
5 Viral Pathogens for the Oregon Health Authority (OHA). In that position, she leads respiratory  
6 viral pathogen surveillance (COVID-19, influenza, RSV) for Oregon within the Acute and  
7 Communicable Disease Prevention Section; she serves as the Senior Health Advisor for COVID-  
8 19, acting as a subject matter expert on testing strategy and policy; she is the principal  
9 investigator for the CDC's Epidemiology and Laboratory Capacity cooperative agreement,  
10 administering \$101 million in funding to support infectious disease epidemiology, public health  
11 modernization, and COVID-19 response; she is the principal investigator for the CDC's  
12 Emerging Infections Program regarding COVID-19, influenza, and RSV hospitalization  
13 surveillance; she collaborates with colleagues in other states to coordinate observational  
14 research; she functions as a public health media spokesperson; and she participates in an  
15 Epidemiologist on-call rotation. (Ex. A7 at 1; Tr. I at 113-115.)  
16

17 53. Dr. Sutton has co-authored the following:  
18

- 19 • "Characteristics of Adults aged 18-49 Years without Underlying  
20 Conditions Hospitalized with Laboratory-Confirmed COVID-19 in the  
21 United States," published in *Clinical Infectious Diseases* (2020);  
22
- 23 • "COVID-19 Investigational Treatments in Use Among Hospitalized  
24 Patients Identified Through the US Coronavirus Disease 2019 –  
25 Associated Hospitalization Surveillance Network," published in *Open  
26 Forum Infectious Diseases*, Oxford University Press (2020);  
27
- 28 • "COVID-19-Associated Hospitalizations Among Health Care  
29 Personnel," published in *Morbidity and Mortality Weekly Report (MMWR)*  
30 (2020);  
31
- 32 • "Risk Factors for Coronavirus Disease 2019 (COVID-19)-Associated  
33 Hospitalization: COVID-19-Associated Hospitalization Surveillance  
34 Network and Behavioral Risk Factor Surveillance System," published in  
35 *Clinical Infectious Diseases* (2020);  
36
- 37 • "Characteristics and maternal and birth outcomes of hospitalized  
38 pregnant women with laboratory-confirmed COVID-19," published in  
39 *MMWR* (2020);  
40
- 41 • "Notes from the Field: Seroprevalence Estimates of SARS-CoV-2  
42 Infection in Convenience Sample – Oregon," published in *MMWR* (2020);  
43
- 44 • "Hospitalization rates and characteristics of children aged < 18 years  
45 hospitalized with laboratory-confirmed COVID-19," published in *MMWR*  
46 (2020);

1  
2 • “Risk factors for intensive care unit admission and in-hospital mortality  
3 among hospitalized adults identified through the US coronavirus disease  
4 2019 (COVID-19)-associated hospitalization surveillance network,”  
5 published in *Clinical Infectious Diseases* (2020);

6  
7 • “Hospitalization rates and characteristics of patients hospitalized with  
8 laboratory-confirmed coronavirus disease 2019,” published in *MMWR*  
9 (2020); and

10  
11 (Ex. A7 at 4.) She has presented on topics such as COVID-19 testing strategies for rural Oregon,  
12 the Oregon Testing Initiative, and residency learning and teaching approaches. (*Id.*)  
13

14 54. Dr. Sutton’s professional writing skills include literature review, systematic review,  
15 protocol development and manuscript preparation, policy memoranda, executive summaries, and  
16 risk assessment development. Her data analysis skills include linear and longitudinal regression,  
17 logistic regression and propensity score analysis, survival analysis, meta-analysis, data mining,  
18 and risk prediction. (Ex. A7 at 5.)  
19

20 55. As a Senior Health Advisor for the OHA on COVID-19 matters, Dr. Sutton conducts  
21 daily reviews on the latest evidence and literature pertaining to the COVID-19 pandemic. (Tr. I  
22 at 115.) In her opinion, peer review of medical literature — whereby colleagues with  
23 appropriate expertise are selected to review an article, provide feedback, and ultimately weigh in  
24 on the appropriateness of publication — is an important process that protects against bias and  
25 misinformation. (*Id.* at 129-130.)  
26

27 56. Dr. Sutton had a significant role in updating the OHA’s “Clinical Care, and  
28 Healthcare Infection Prevention and Control Guidance for COVID-19,” particularly with regard  
29 to outpatient and general clinic settings. (Tr. I at 115-116.) In her opinion, a healthcare setting  
30 such as a primary care clinic “presents a great opportunity for a super spreader event,” given that  
31 a primary care physician (and any ancillary staff) might treat as many as 40 patients in a day;  
32 between 40 and 60 percent of people infected with COVID-19 may be asymptomatic but  
33 infectious; and many people who visit a healthcare facility have underlying comorbidities that  
34 may place them at greater risk of harm from COVID-19. (*Id.* at 119-120.)  
35

36 57. Viral particles called virions exit a host body in droplets (*e.g.*, saliva, sputum, nasal  
37 secretions). The term “droplet” is often used to mean droplets that are at least five microns in  
38 size, while the term “aerosol” may be used for droplets that are less than five microns. (Tr. I at  
39 136-137.) Many scientists think that the smaller droplets (*i.e.*, aerosols) are the most dangerous  
40 because they are the most common and because they can shrink significantly via evaporation  
41 after leaving the host body and remain suspended in the air. These small suspended particles can  
42 accumulate in confined spaces, travel around in air flow, and be easily inhaled. (*Id.* at 123-124,  
43 137.) Large droplets, in contrast to smaller droplets, travel in projectiles and may land in a  
44 person’s eyes, nose, or mouth. (*Id.* at 137-138.)  
45

46 ///

1           58. The SARS-CoV-2 virion ranges in size, with the average size being approximately  
2 0.1 microns. (Tr. I at 120, 123, 136-137.) In Dr. Sutton's opinion, COVID-19 produces a large  
3 number of viral particles in saliva and sputum, with studies showing that 10 times more virions  
4 are produced by COVID-19 than by SARS-CoV. (*Id.* at 138.)  
5

6           59. In Dr. Sutton's opinion, the size of the droplet determines whether a virion will pass  
7 through a mask, and not the size of the virion itself. (Tr. I at 142.) In Dr. Sutton's opinion,  
8 masks block large droplets "really, really well." (*Id.* at 139, 200.) How well masks block small  
9 droplets or aerosols is determined primarily by fit. (*Id.* at 139; *see also id.* at 200-201.)  
10

11           60. While recognizing that physical distancing, handwashing, surface cleaning, and  
12 minimization of contact between non-household members is important, Dr. Sutton believes the  
13 most important measure to mitigate against the risk of COVID-19 transmission in a healthcare  
14 clinic setting is masking. (Tr. I at 123-124.) The role of masking in a clinic setting is to protect  
15 patients, healthcare personnel, and the community. (*Id.* at 120-121.) In Dr. Sutton's opinion,  
16 healthcare personnel who do not mask in a clinical setting would almost certainly become  
17 infected with COVID-19 over time, and such infection might not result in symptoms, placing  
18 patients at risk of contracting the virus from such personnel unknowingly. (*Id.* at 122.)  
19

20           61. Dr. Sutton believes that masks have two potential benefits: 1) they serve as source  
21 control by blocking droplets from the wearer's mouth and nose; and 2) they serve as protection  
22 by blocking droplets from entering others' mouths and noses. (Tr. I at 120-121, 138-139.) In  
23 Dr. Sutton's opinion, the primary role that masks play is with regard to source control.<sup>31</sup> (*Id.* at  
24 143.)  
25

26           62. In Dr. Sutton's opinion, masks may stop droplets in two different ways: 1)  
27 mechanically; and 2) electrostatically. With cloth and non-medical grade masks that do not  
28 utilize electrostatic capture, droplets that are larger than the hole (*i.e.*, pore) size in the cloth are  
29 stopped. If a mask has electrostatic capture, even droplets that are smaller than the pore size in  
30 the cloth can be stopped or caught by the mask. (Tr. I at 140.)  
31

32           63. Dr. Sutton does not believe that cloth masks have the effect of aerosolizing the  
33 droplets exhaled by the wearer. (Tr. I at 202-203.) In Dr. Sutton's opinion, any mask is better  
34 than no mask because even a poorly fitting cloth mask "will block large droplets quite well."  
35 (*Id.* at 143.) In Dr. Sutton's opinion, homemade double-layered cloth masks that fit well can  
36 filter even small particles effectively, potentially even down to two microns. (*Id.* at 140-141.)  
37

38           64. Moisture captured in a mask is evidence that the mask is working to capture droplets  
39 from a person's mouth and nose. Moisture affects the efficacy of masks, so the general  
40 recommendation (including from the CDC) is to change out a mask when it becomes soiled or  
41 wet. In Dr. Sutton's opinion, cloth masks should be washed after a single use. In her opinion,  
42 failure to do so can lessen the protective effect of the mask, but it does not pose a hazard to the  
43 wearer, absent some extreme circumstance. (Tr. I at 141-142, 215-216.)  
44  
45

46           <sup>31</sup> Dr. Sutton testified at hearing that "when you wear a mask you are actually protecting others more than you are  
yourself." (Tr. I at 143.)

1           65. Dr. Sutton acknowledges that masks do not eliminate the risk of transmission of  
2 virus particles, but in her opinion, masks reduce such transmission “by a significant proportion,”  
3 particularly when both the infected person and the person who may potentially become infected  
4 are masked. (Tr. I at 144.) In Dr. Sutton’s opinion, there is “absolutely no debate at this point in  
5 time [regarding] whether masks reduce COVID-19 transmission.” (*Id.* at 124-125, 173.) She  
6 believes that masking is now known to be so clearly protective against the transmission of  
7 COVID-19 that a researcher could not obtain ethical board approval for a randomized control  
8 study in which a “control” group of individuals is asked not to wear a mask because it would  
9 clearly represent harm to the group. (*Id.* at 125.) She believes that the degree of effectiveness of  
10 masking varies by the type and fit of the mask, the conduct of the wearer, and other external  
11 circumstances. (*Id.* at 124, 139.)  
12

13           66. Although randomized controlled trials have traditionally been considered the gold  
14 standard for research, in Dr. Sutton’s opinion, randomized controlled trials may not be feasible  
15 for an emerging pathogen in a fast-paced pandemic like the current one. She believes that  
16 observational studies and research — while typically considered to be of lower quality than  
17 randomized controlled trials — when accumulated over time can constitute compelling evidence.  
18 In her opinion, there is accumulated evidence from observational research showing that masking  
19 is associated with a reduced risk of COVID-19 transmission. (Tr. I at 134-135.)  
20

21           67. In Dr. Sutton’s opinion, the benefit of a systematic review is that it consists of an  
22 exhaustive review of all available literature regarding an issue, and the benefit of a meta-analysis  
23 is that all the data from all the different studies is pooled to produce a pooled effect estimate.<sup>32</sup>  
24 (Tr. I at 127-128; *see also id.* at 171.)  
25

26           68. In Dr. Sutton’s opinion, masks have long been used in healthcare settings safely,  
27 masking for both healthcare providers and patients is the standard of care in influenza and  
28 respiratory disease outbreaks, and there is “no evidence that masks are not safe when used  
29 appropriately.” (Tr. I at 144-145.) She recognizes that some people do not tolerate masks well,  
30 and she supports the masking exemption for patients and caregivers who are unable to tolerate  
31 wearing masks. (*Id.* at 152, 162.)  
32

33           69. In Dr. Sutton’s opinion, there can be long-term health consequences for people who  
34 contract COVID-19. She believes it is common for COVID-infected persons to have persistent  
35 symptoms at 30 days, and some people (referred to as “long haulers”) have experienced  
36 persistent, sometimes disabling, symptoms many months after infection. (Tr. I at 160.) Some  
37 COVID-19 infected patients have experienced scarring of the lungs, which can have long-term  
38 consequences and cause persistent symptoms such as shortness of breath and fatigue. (*Id.* at  
39 161.)  
40

41           70. In Dr. Sutton’s opinion, the PCR test is the best test for COVID-19, but “it is in no  
42 way perfect.” (Tr. I at 194.) Dr. Sutton disagrees with Licensee’s assertion that the PCR test  
43 produces a significant amount of false positives. On the contrary, Dr. Sutton believes that the  
44

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45           <sup>32</sup> Dr. Sutton explained that an advantage of a pooled effect estimate is that if, for example, you have a small study  
46 that shows no benefit but a larger study that does show benefit, there is a process to average and weigh the studies to  
get “a better idea of what’s going on.” (Tr. I at 128.)

1 bigger issue with the PCR test is the incidence of false negatives. For adults being admitted to  
2 the hospital with symptoms of COVID-19, their first PCR test is positive only 88 percent of the  
3 time. (*Id.*)  
4

5 71. In Dr. Sutton's opinion, Licensee's manner of managing his clinic during the  
6 COVID-19 pandemic constituted a danger to the health and safety of clinic patients, clinic staff,  
7 and the public. (Tr. I at 163.)  
8

9 *B. Dawn Nolt, MD, MPH*  
10

11 72. Dr. Nolt has a Bachelor of Science degree in Biology from the Massachusetts  
12 Institute of Technology. In 1996, she received a Medical Degree and a Masters of Public Health  
13 degree from George Washington Medical School. In 1999, she completed an internship and  
14 residency in Pediatrics at Affiliated Hospitals in Houston, Texas. In 2002, she completed a  
15 fellowship in Pediatric Infectious Diseases at Children's Hospital of Pittsburgh. She is board  
16 certified in both Pediatrics and Pediatric Infectious Diseases. She was previously licensed as a  
17 physician in Pennsylvania and is currently licensed in Oregon. (Ex. A8 at 1-2; Tr. II at 179-180.)  
18

19 73. Dr. Nolt has particular scholarly interest and expertise in hospital epidemiology and  
20 infection control, vaccinations, and infectious outcomes of pediatric hematology/oncology  
21 patients. She has received numerous research grants, fellowship awards, and contracts from  
22 entities such as the National Institutes of Health/National Institute of Allergy and Infectious  
23 Diseases, Johns Hopkins University, Duke University, Boston School of Medicine, Children's  
24 Hospital of Philadelphia, Pediatric Infectious Diseases Society, and Merck. (*See* Ex. A8 at 3-5.)  
25 Her work has been extensively published in peer-reviewed medical journals such as *Pediatric*  
26 *Infectious Disease Journal*, *Clinical Infectious Diseases*, *Infection and Immunity*, *Journal of*  
27 *Immunology*, *Journal of Clinical Pathology*, *Journal of Experimental Medicine*, *Pediatrics*,  
28 *Pediatric Dermatology*, *PLOS Pathogens*, *Pediatric Blood Cancer*, *Journal of Pediatric Surgery*,  
29 *Pediatric Critical Care Medicine*, and *MedRead Journal of Pharmacy Science*. (*See id.* at 5-8.)  
30 In 2003, she co-authored a chapter titled, "Pediatrics in a Page," in a book on Infectious Disease  
31 (*Id.* at 7.) In 2020, she co-authored a chapter in a book on Hospital Infection Prevention for  
32 Pediatric Transplant Recipients and Oncology Patients titled, "Pediatric Transplant and  
33 Oncology Infectious Diseases." (*Id.*) She has presented and lectured extensively on issues  
34 relating to infectious disease, immunization, and infection control at the international, national,  
35 regional, local, and institutional level. She has provided legislative testimony, consultation, and  
36 input at the state and federal level on issues such as vaccine exemptions, Zika virus in the Pacific  
37 Northwest, measles vaccination in the Pacific Northwest, Oregon Health and Science  
38 University's (OHSU's) response to COVID-19, and COVID-19 risk-reduction measures. (*See*  
39 *id.* at 9-13.)  
40

41 74. Dr. Nolt is a Member and Fellow of the American Academy of Pediatrics, as well as  
42 a Member of the Pediatric Infectious Diseases Society, the Infectious Diseases Society of  
43 America, the Infectious Diseases Society of Oregon, and the Children's Oncology Group.  
44 Since 2015, she has been an *ad hoc* Journal Referee/Reviewer for medical publications such as  
45 *Clinical Infectious Diseases*, *Emerging Infectious Diseases Journal*, *JAMA Pediatrics*, *Pediatric*  
46 *Blood and Cancer*, and *Journal of Pediatrics*. Since 2015, she has served as a Member of the

1 Committee on Infectious Diseases, which monitors current developments in the prevention,  
2 diagnosis, and treatment of infectious diseases. Since 2019, she has been a Member of the  
3 Antimicrobial Stewardship Centers of Excellence (CoE) Subcommittee, which provides ongoing  
4 review and evaluation of CoE program goals, design, and implementation to the Infectious  
5 Diseases Society of America. Since 2020, she has been a Member of the Governor's COVID-19  
6 Medical Advisory Panel and a Member of the Western Regional Alliance for Pediatric  
7 Emergency Management. (Ex. A8 at 11-12.)  
8

9 75. From 2002 to 2006, Dr. Nolt was a Staff Physician and Instructor and Assistant  
10 Professor of Pediatrics/Pediatric Infectious Diseases at Children's Hospital of Pittsburgh. From  
11 2006 to 2014, she was an Assistant Professor of Pediatrics/Pediatric Infectious Diseases at  
12 OHSU. From 2011 to 2016, she was also a Consulting Staff Physician for Shriners Hospital for  
13 Children – Portland. From 2014 to 2020, she was an Associate Professor of Pediatrics/Pediatric  
14 Infectious Diseases at OHSU. Since 2020, she has been a Professor of Pediatrics/Pediatric  
15 Infectious Diseases at OHSU. (Ex. A8 at 2-3; Tr. II at 180.)  
16

17 76. Since 2006, Dr. Nolt has been a Staff Physician at Doernbecher Children's Hospital  
18 (Doernbecher). Since 2013, she has served as the Director of Pediatric Oncologic and Transplant  
19 Infectious Diseases and the Medical Director of the Pediatric Antimicrobial Stewardship  
20 Program at Doernbecher. Since 2015, she has served as the Pediatric Medical Director for  
21 Infection Prevention and Control at Doernbecher. (Ex. A8 at 2; Tr. II at 180.)  
22

23 77. Dr. Nolt has developed various curricula at OHSU and Doernbecher, including a  
24 handbook regarding antimicrobial stewardship for Pediatric Residents, training curriculum  
25 regarding antimicrobial stewardship for Pediatric Nursing staff, and Clinical Practice Guidelines  
26 for Doernbecher regarding encephalitis, neutropenic fever, and pediatric urinary tract infection.  
27 She has advised and mentored OHSU Medical Students, Pediatric Residents, and Pediatric  
28 Hematology/Oncology Fellows, and between 2012 and 2019, she served as a Member of  
29 OHSU's Scientific Oversight Committee. (Ex. A8 at 17-18.) From 2010 to 2020, she served as  
30 the Co-Chair of OHSU's Institutional Biosafety Committee. Since 2015, she has served as the  
31 Co-Chair of OHSU's Infection Control Committee. Since 2017, she has been a Member of  
32 OHSU's Antimicrobial Subcommittee of Pharmacy and Therapeutics. Since 2020, she has been  
33 the Co-Chair of OHSU's COVID-19 Clinical Lab Testing Taskforce and its COVID-19 Clinical  
34 Vaccine Taskforce. (*Id.* at 12; Tr. II at 181.)  
35

36 78. In Dr. Nolt's opinion, transmission of SARS-CoV-2 occurs primarily through  
37 respiratory droplets and airborne contact. (Tr. II at 182.) In Dr. Nolt's opinion, although there  
38 are no randomized controlled trials showing that masks protect against transmission of COVID-  
39 19, there is "an accumulation of very good evidence showing that masks do decrease COVID-19  
40 transmission." (*Id.* at 184-185, 226.) In Dr. Nolt's opinion, masking reduces the risk of  
41 transmission of COVID-19, and it is the standard of care for healthcare workers to wear masks in  
42 clinical settings, including direct patient care, during the COVID-19 pandemic. (*Id.* at 190-191.)  
43

44 79. In Dr. Nolt's opinion, masking is important for two reasons: 1) it serves as source  
45 control for the person who may be talking, coughing, or singing and inadvertently extruding  
46 virus; and 2) it serves as a barrier to protect people who are exposed to the source of virus. In

1 Dr. Nolt's opinion, a COVID-19 infected person can be contagious even if they are showing no  
2 signs or symptoms of infection. The threshold of virus that causes infection is unknown. But  
3 once some threshold is achieved, there is an incubation period for the virus to replicate, and then  
4 the person who is infected can pass the infection on to other people. (Tr. II at 182-184.)  
5

6 80. In Dr. Nolt's opinion, transmission of SARS-CoV-2 is based on three factors: dose;  
7 duration; and distance. Dose refers to the amount of respiratory secretions that are expelled by a  
8 source, duration refers to exposure over time, and distance refers to how far you are from the  
9 source. Dr. Nolt believes that dose can be controlled by masking. (Tr. II at 186-187.)  
10

11 81. Dr. Nolt acknowledges that wearing a mask, particularly a tight-fitting mask such as  
12 an N95, could cause a pressure headache and that prolonged mask wearing could cause contact  
13 dermatitis or acne. She points out that such issues are minor and treatable. In her opinion,  
14 numerous studies show that there is no risk of increased CO2 toxicity or decreased O2 from  
15 mask wearing. (Tr. II at 199-200.)  
16

17 82. In Dr. Nolt's opinion, Licensee's manner of managing his clinic during the COVID-  
18 19 pandemic constituted a danger to the health and safety of clinic patients, clinic staff, and the  
19 public. (Tr. II at 212.) Dr. Nolt opined as follows:  
20

21 Mask wearing has been proven to inhibit virus transmission and particle  
22 transmission between people, and during this ongoing pandemic, we use  
23 the best available evidence we can to stem this pandemic and so we should  
24 use all measures.  
25

26 Mask wearing is not perfect, but mask wearing, physical distancing, hand  
27 hygiene, cleaning surfaces, all those should be employed to not only keep  
28 our patients safe but to keep the healthcare staff that we have \* \* \* safe  
29 and keep the community safe; so masking is very important and should be  
30 practiced.  
31

32 (*Id.* at 212-213.) In Dr. Nolt's opinion, if Licensee returned to practice and followed his same  
33 clinic protocols regarding masking, his patients and the public would be subject to risk of harm.  
34 (*Id.* at 213.)  
35

36 *C. David Farris, MD*  
37

38 83. Dr. Farris graduated from the University of California at San Diego School of  
39 Medicine in 1981. In 1982, he completed an internship at Maricopa County General Hospital's  
40 Department of Obstetrics and Gynecology. In 1985, he completed a residency at UCLA Medical  
41 Center's Department of Anesthesiology (UCLA). In 1986, he completed a fellowship in  
42 pediatric anesthesiology at UCLA. From 1982 to 1985, he performed *locum tenens* emergency  
43 medicine in emergency departments in four U.S. states. In 1985, he performed part-time general  
44 practice anesthesiology at Cedars-Sinai Medical Center. From 1986 to 2019, he performed  
45 pediatric, cardiac (adult and pediatric/congenital), trauma, and general practice anesthesiology at  
46 Emanuel Hospital/Randall Children's Hospital. From 1994 to 1996, he worked part-time as a



1 pediatric intensivist in the Pediatric Intensive Care Unit at (now) Randall Children's Hospital.  
2 From 1996 to 2019, he served as a clinical assistant professor at OHSU's Department of Surgery.  
3 (Ex. A19 at 1-2; Tr. II at 10.)  
4

5 84. Dr. Farris has been certified by the American Board of Anesthesiology since 1987.  
6 He is licensed as a physician in Oregon. He previously served as the Chair of the Department of  
7 Anesthesiology at Emanuel Hospital (from 1990 to 1992), Legacy Portland Hospital (from 1993  
8 to 1994) and Legacy Emanuel/Randall Children's Hospitals (from 2007 to 2008). From 1999 to  
9 2001, he served as a Member of the American Society of Anesthesiologists' Committee on  
10 Practice Management. At Emanuel Hospital he has served as the Director of Pediatric  
11 Anesthesia (from 1995 to 2011) and the Director of Cardiac Anesthesia (from 2000 to 2007).  
12 Since 2004, he has served as the Co-Director of the Bloodless Medicine and Surgery Program for  
13 Legacy Health System. From 2012 to 2017, he served as a Member of Legacy Emanuel/Randall  
14 Children's Hospitals' Peer Review Coordination Committee. (Ex. A19 at 1-2; Tr. II at 10-11.)  
15 In 2016, he was awarded the "Timothy J. Campbell Award for Excellence in Pediatric Surgery or  
16 Anesthesia" at Randall Children's Hospital. (Ex. A19 at 1.) He has presented and lectured on  
17 topics such as bloodless medicine, rapid sequence intubation, tracheal intubation, neonatal  
18 anesthesia, pediatric anesthesia, airway management in trauma, and pediatric airway  
19 emergencies. He has been published in the *Journal of the American College of Emergency*  
20 *Physicians* (1979), *Clinical Toxicology* (1980), and *Anesthesia & Analgesia* (1988 – letter). (*Id.*  
21 at 2-3.)  
22

23 85. Since 2019, Dr. Farris has served as the Board's Medical Director. (Ex. A19 at 1; Tr.  
24 II at 11.) As the only medically-trained person out of the approximately 40 Board employees  
25 (which does not include Board members), he is involved in the medical aspects of Board  
26 investigations and licensing matters, and he serves as a resource for medical issues. He reviews  
27 each investigation and investigative report before it is presented to the Board's Investigative  
28 Committee. If a particular investigation does not require his input regarding medical care, he  
29 simply signs off on the investigator's report and forwards the matter to the Investigative  
30 Committee. If, however, an investigation involves matters such as substandard medical care, Dr.  
31 Farris will prepare a summary for the Investigative Committee to accompany the investigator's  
32 report. (Tr. II at 11-12.)  
33

34 86. As an anesthesiologist, Dr. Farris has expertise in monitoring CO2 levels and in the  
35 concepts of CO2 retention and dead space inhalation. (Tr. II at 12.) The CO2 blood level for a  
36 typical person is 40 mm/Hg (millimeters of mercury). A person with lung disease might have a  
37 CO2 blood level of 50 mm/Hg. (*Id.* at 53.) Dr. Farris opines, as follows:  
38

39 The level of carbon dioxide in the body in an awake, healthy person is one  
40 of the most tightly regulated parameters we can measure. The body  
41 compensates unconsciously by controlling the amount of air that we  
42 exchange minute by minute to maintain carbon dioxide within a very tight  
43 range, generally expressed as 40 millimeters of mercury[.]  
44

45 \* \* \* \* \*

46 ///

1 [I]f you think about the way that we breathe, it is piston-like. We take in  
2 air, we exhale air; so there is not a continuous flow past the gas exchange  
3 part of the lungs. The alveoli of the lungs, the tiny saccules deep in the  
4 lungs are where gas exchange occurs. So it is only that air, that gas, that is  
5 delivered to the alveoli where gas exchanges occurs. As we inhale, there  
6 is a certain amount of air that sits in the nose, mouth, and trachea and the  
7 major airways of the lungs that is not exposed to any gas exchanging  
8 tissue. So that volume of gas is called dead space ventilation. It is not  
9 participating in gas exchange. So the typical breath that a person takes is  
10 450 to 500 milliliters. Of that volume, about 150 mLs is generally  
11 considered dead space ventilation[.]  
12

13 (*Id.* at 12-14.) In Dr. Farris' opinion, wearing a mask, particularly a well-fitted one, can double  
14 the dead space ventilation, requiring the body to increase the amount of gas the person is  
15 exchanging minute to minute to tightly regulate and maintain the CO<sub>2</sub> level at approximately 40  
16 mm/Hg in the arteries and approximately 44 or 45 mm/Hg in the veins. This can be  
17 accomplished by breathing more deeply or more frequently, and "it is the product of those two  
18 that produce the amount of gas that you exchange in a given minute," which is referred to as  
19 "minute ventilation." (*Id.* at 14-15; 78.) In Dr. Farris' opinion, if a person is wearing a loosely  
20 fitted mask, then there is likely some degree of cross-ventilation and fresh air displacing some of  
21 the exhaled carbon dioxide, and the body would not have to increase its minute ventilation as  
22 much as with a tight-fitting mask. (*Id.* at 15-16.)  
23

24 87. In Dr. Farris' opinion, symptoms of CO<sub>2</sub> toxicity would only be expected to occur if  
25 a person's CO<sub>2</sub> level reached as high as 90 mm/Hg, which is the equivalent of holding one's  
26 breath for one hour. In Dr. Farris' opinion, symptoms of CO<sub>2</sub> toxicity would not occur under  
27 conditions created by mere mask-wearing, and would only occur at a level of CO<sub>2</sub> "not  
28 achievable short of an unconscious person or a person basically being suffocated." (Tr. II at 53-  
29 54.)  
30

31 88. In Dr. Farris' opinion, although some vital sign parameters have been shown to  
32 change in trivial directions from mask wearing, the body quickly compensates, there is no  
33 significant increase in CO<sub>2</sub> levels or decrease in O<sub>2</sub> levels, and masks do not cause physiologic  
34 harm to mask wearers. (Tr. II at 49-50.) He opines that even if masks cause retention of CO<sub>2</sub>,  
35 the oxygen level as measured does not change and, despite increasing the acidic state of the  
36 body, there is no physiologic harm caused. (*Id.* at 50, 52.) He believes that side effects caused  
37 from mask-wearing such as skin breakdown or impetigo, though minor, may warrant exemption  
38 from masking mandates. (*Id.* at 51.)  
39

40 89. In Dr. Farris' opinion, a literature review, which summarizes known data, is highly  
41 useful for clinicians because it provides a summary of what is known and what is not known  
42 about a subject. A literature review is not itself a scientific study but, rather, a summation of  
43 scientific studies. (Tr. II at 65-66.)  
44

45 90. Dr. Farris describes the factors that inform the quality of a meta-analysis as follows:  
46

///

1 A meta-analysis \* \* \* takes the data from a number of studies and creates  
2 a pooled set of data so that you might have a study that involved a  
3 thousand patients and four studies that involved 200 patients, and if you  
4 determine that the patients are similar enough in their characteristics, then  
5 you can analyze a pool of 1800 patients, which obviously has far more  
6 reaching implications than any of the studies individually[.]

7  
8 [D]etermining that the patients' subpopulations in the different studies are  
9 similar enough and that all the parameters that you are interested in have  
10 been measured \* \* \* [is] what complicates the idea of a meta-analysis,  
11 what complicates the execution.

12  
13 The idea is \* \* \* to pool all the subjects in a number of studies and draw  
14 conclusions on a much broader basis, but the complicating factors in the  
15 execution are that not all the studies may have measured all the relevant  
16 parameters in the way that you want them to, may not have been  
17 controlled in the way that you want them to.

18  
19 [I]f you find that the study populations that you are pooling do have a high  
20 degree of similarity, then the validity of the meta-analysis can be  
21 considered quite good.

22  
23 If you are trying to draw from subject populations that are quite disparate  
24 and you are missing data sets in a number of them, then the conclusions  
25 would be suggestive, less convincing.

26  
27 (Tr. II at 66-68.)  
28

29 91. In Dr. Farris' opinion, it is fundamental general medical knowledge that respiratory  
30 viruses are primarily transmitted through "respiratory droplets." (Tr. II at 27.) Based on his  
31 knowledge, experience, and review of medical literature, Dr. Farris opines that the principal  
32 mode by which people are infected with SARS-CoV-2 is through exposure to respiratory  
33 droplets from the lungs, trachea, oropharynx, and saliva, which all contain fluid known to carry  
34 infectious virus. (*Id.* at 16, 27; *see id.* at 34-45 (discussion of the medical literature he  
35 reviewed).)

36  
37 92. In Dr. Farris' opinion, "there is little doubt that masks are effective" in reducing the  
38 transmission of respiratory viruses, including SARS-CoV-2. (Tr. II at 19-20.)  
39

40 93. In Dr. Farris' opinion, "if we decrease the amount of virus we are emitting into the  
41 atmosphere, we are decreasing the likelihood that anyone will contract an infection and \* \* \*  
42 likely decreasing the severity" of any such infection due to considerations of the viral load. (Tr.  
43 II at 20-21.) In Dr. Farris' opinion, no one has yet quantified the number of viral particles that  
44 are required to produce an infection in a person. He believes that although it is theoretically  
45 possible that a single virion attached to cells in the lining of a lung could eventually replicate  
46

///

1 itself to the point of producing disease, such a scenario is “extremely unlikely.” (*Id.* at 21.) Dr.  
2 Farris opines as follows:  
3

4 [I]t stands to reason that if a person inhaled \* \* \* a dozen respiratory  
5 droplets and exposed a given segment of the lung to \* \* \* [for example,] a  
6 million viral particles and a virus set up shop in one small part of the lung,  
7 as it spreads over time, it would be a slower spread than if the person  
8 inhaled 10 times that many respiratory droplets and the virus set up shop  
9 in 10 parts of the lung.  
10

11 It stands to reason that the slower spread could be more readily contained  
12 by the immune system than the person who inhaled 10 times that much  
13 virus and would potentially, then, be subjected to an overwhelming  
14 disease load before the immune system caught up.  
15

16 So the concept of the viral load is highly relevant in terms of not only the  
17 likelihood of a person developing any infection at all but developing a  
18 symptomatic infection and \* \* \* the ability to pass the infection along.  
19

20 So as a mask diminishes, without eliminating, \* \* \* the number of  
21 respiratory droplets and aerosols in the air, then it stands to reason that the  
22 viral load would decrease even for those who were exposed. And that is  
23 why the masks are known to diminish \* \* \* measurable contagion. It’s  
24 probably that it is not only diminishing measurable disease but viral  
25 burden in those who are asymptomatic.  
26

27 (*Id.* at 21-22.)  
28

29 94. In Dr. Farris’ opinion, although not impossible, it is highly unlikely that none of  
30 Licensee’s patients contracted COVID-19 while under his care at the clinic. Dr. Farris questions  
31 how Licensee would even know whether any patients contracted COVID-19 from the clinic  
32 because Licensee did not do any cultures or testing, making it highly unlikely that he would  
33 know of a patient’s asymptomatic infection. In Dr. Farris’ opinion, patients who treated with  
34 Licensee at the clinic during the pandemic could have developed a COVID-19 infection with a  
35 median time of five days after potential exposure at the clinic, and Licensee would not  
36 necessarily know about it. (Tr. II at 56-57.)  
37

38 95. In Dr. Farris’ opinion, the PCR test has a high rate of false negatives. (Tr. II at 58.)  
39

40 96. In Dr. Farris’ opinion, Licensee’s continued practice of medicine constitutes an  
41 immediate danger to the public. (Tr. II at 62.)  
42

43 *D. Thomas Stern, MD*  
44

45 97. Dr. Stern graduated from the University of Arkansas’ School of Medicine in 1993  
46 and subsequently completed residencies in Internal Medicine and Pediatrics, and fellowships in

1 Pulmonary Medicine, Critical Care Medicine, and Sleep Medicine at Case Western University  
2 (Case Western). He also completed a one-year fellowship with the Agency for Healthcare  
3 Research and Quality (AHRQ). He has a Master's Degree in Clinical Research from Case  
4 Western. He holds board certifications in Sleep Medicine, Pulmonary Medicine, and Critical  
5 Care Medicine. He is licensed as a physician in North Carolina. He is not licensed as a  
6 physician in Oregon. (Tr. IV at 174-175.)  
7

8 98. Dr. Stern currently oversees a Pulmonary, Sleep, and Clinical Research office, where  
9 he primarily practices Sleep Medicine and Pulmonary Medicine, consults on clinical trial  
10 designs, and runs research trials for pharmaceutical and medical device companies. He has  
11 expertise regarding clinical trials and research. (Tr. IV at 175-176, 234.) In approximately 2018,  
12 he was part of a team that designed "the most efficient air filtration system in the world." (*Id.* at  
13 177.) The process involved conducting extensive research into the data regarding the use of  
14 masks in preventing respiratory disease and collaborating with a group of design engineers. The  
15 filtration system is currently sold under the company name Celios. Dr. Stern did not receive  
16 direct compensation for his work in helping to design the filtration system, but he did receive  
17 Celios stock. (*Id.* at 177, 244-245.)  
18

19 99. Dr. Stern follows the directives of his state and wears a face mask as required in the  
20 clinic. His facemask of choice is a cloth face mask because he considers it the most comfortable  
21 of the various types. All staff at his clinic wear face masks when having patient contact, with the  
22 exception of one employee who is immunized against COVID-19, and wears a face shield in  
23 place of a mask. In the waiting room of the clinic, patients practice social distancing. Every  
24 patient is screened immediately at the front desk, and such screening includes temperature and  
25 pulse readings. If a patient shows any signs of COVID-19, the patient is isolated in a room with  
26 a Celios air filter. Most of Dr. Stern's patients (and accompanying visitors) wear masks at the  
27 clinic. (Tr. IV at 223-224, 234-237, 242.)  
28

29 100. In the hierarchy of studies, Dr. Stern believes that the best individual study is a  
30 randomized controlled clinical trial. In his opinion, multiple randomized controlled clinical trials  
31 that all came to the same conclusion would constitute even stronger evidence. He believes that  
32 retrospective cohort studies can be useful to come up with a question to design a randomized  
33 trial, but he is opposed to making policy decisions based on such studies alone. He believes that  
34 case-controlled studies and observational studies have some value, but he does not think it is  
35 wise to rely on them to make policy decisions. (Tr. IV at 200-202, 228; *see also* Ex. R43 at 2.)  
36 For scientific research purposes, Dr. Stern believes there is no real substitute for a randomized  
37 controlled clinical trial. (Tr. IV at 202.)  
38

39 101. In Dr. Stern's opinion, research between June 2015 and 2017 demonstrates a "clear  
40 understanding" that masks are not an effective method of curtailing respiratory diseases, and he  
41 believes that remained the prevailing opinion until June 2020. (Tr. IV at 177.) On June 5, 2020,  
42 the WHO published an interim guidance document titled "Advice on the use of masks in the  
43 context of COVID-19." (Ex. R81 at 1-16; Tr. IV at 177-178.) With regard to the issue of  
44 continuous use of medical masks by healthcare workers in areas of known or suspected  
45 community transmission, the document states, in part:  
46

///  
46

1           There are currently no studies that have evaluated the effectiveness and  
2           potential adverse effects of universal or targeted continuous mask use by  
3           health workers in preventing transmission of SARS-CoV-2. Despite the  
4           lack of evidence the great majority of the WHO COVID-19 IPC  
5           [Guidance Development Group] members supports the practice of health  
6           workers and caregivers in clinical areas (irrespective of whether there are  
7           COVID-19 or other patients in the clinical areas) in geographic settings  
8           where there is known or suspected community transmission of COVID-19,  
9           to continuously wear a medical mask throughout their shift, apart from  
10          when eating and drinking or changing the mask after caring for a patient  
11          requiring droplet/contact precautions for other reasons (e.g., influenza), to  
12          avoid any possibility of cross-transmission.  
13

14       (Ex. R81 at 4.) In Dr. Stern's opinion, the above does not constitute evidence-based medicine,  
15       and the WHO's recommendation for universal masking by healthcare workers despite a lack of  
16       evidence does not constitute sound decision-making. (Tr. IV at 177-178, 222-223.)  
17

18           102. In Dr. Stern's opinion, COVID-19 is transmitted via direct contact with droplets  
19       and via aerosol, and there is no "definitive data" to show that one method of transmission is more  
20       common than the other. (Tr. IV at 176.) He believes that COVID-19 "spreads like wildfire."  
21       (*Id.*)  
22

23           103. In Dr. Stern's opinion, with regard to disease transmission by respiratory routes, the  
24       only respiratory particles that really matter are the ones that are smaller than 10 microns. (Tr. IV  
25       at 185; *see* Ex. R36 at 12.) In his opinion, the smaller the viral particle, the more infectious it is.  
26       He believes that for masks to work effectively, they must be capable of blocking particles that  
27       are two microns or less in size. Because SARS-CoV-2 has a particle size of 0.12 microns, he  
28       believes a mask must be capable of filtering out 0.5 microns or less to be effective. (Tr. IV at  
29       186-187.)  
30

31           104. In Dr. Stern's opinion, the second SARS-CoV-2 droplets leave a person, the  
32       droplets are under the influence of their surrounding environment. The fluid in the droplet is  
33       completely evaporated in a second, so just the virion is remaining. (Tr. IV at 183.) He believes  
34       that coronavirus and flu virus are "extremely similar" in physical properties, so they can be  
35       expected to behave similarly according to the laws of physics. (*Id.* at 181-182, 209-210; *see* Ex.  
36       R45.)  
37

38           105. In Dr. Stern's opinion, there is "a wealth of data" showing that masks are not  
39       effective for viral respiratory diseases. (Tr. IV at 179.) He believes the data overwhelmingly  
40       supports a conclusion that masks do not prevent the spread of respiratory droplets, and that cloth  
41       masks can actually do more harm than good by increasing the number of respirable particles.  
42       (*See id.* at 184, 222, 241.) Dr. Stern opines that because there is currently no data to show that  
43       masks prevent the spread of COVID-19, it would not be unethical to do a randomized controlled  
44       study regarding COVID-19 masking. (*Id.* at 214-215.)  
45

46       ///

1           106. In Dr. Stern's opinion, different masks perform differently in capturing respiratory  
2 droplets. In Dr. Stern's opinion, a surgical mask could be expected to capture approximately 50  
3 percent of the respiratory droplets that come from a mask worn by a SARS-CoV-2 infected  
4 source. (Tr. IV at 242.)  
5

6           107. Dr. Stern believes the filter material on N95 masks "does a good job catching  
7 droplets." (Tr. IV at 242-243, 184.) In his opinion, it is very difficult to make an airtight seal  
8 between a mask and a person's face. He believes that even though an N95 mask does "a much  
9 better job sealing against the face than a cloth mask, \* \* \* they still fail the majority of times in  
10 clinical trials when they are trying to block out viruses." (*Id.* at 189.)  
11

12           108. When evaluating the efficacy of masks to block the transmission of viral respiratory  
13 particles, the gold standard to which Dr. Stern compares masks is that of the filter system he  
14 helped to design that can filter out "99.999996 percent of all particles 10 nanometers in size and  
15 larger[,] so 1/12 the size of the virus." (*See* Tr. IV at 190; *see also id.* at 241-242.<sup>33</sup>)  
16

17           109. The highest respirator efficiency is a powered air purifying respirator, called a  
18 PAPR, which costs approximately \$1,200. (Tr. IV at 189.) In Dr. Stern's opinion, given the  
19 level of protection afforded by a PAPR, every healthcare worker should ideally have access to  
20 this type of respirator to protect themselves from viral respiratory illness on the job. (*See* Tr. IV  
21 at 215.)  
22

23           *E. Kristen Meghan Kelly*  
24

25           110. Ms. Kelly has 18 years of experience in the field of Occupation and Environmental  
26 Toxicology, specifically in the field of Industrial Hygiene.<sup>34</sup> As a disabled Veteran, she is now  
27 medically retired from field work. She is currently a "Health Freedom and Informed Consent"  
28 Educator and Volunteer, and she publicly presents on topics such as health hazard controls,  
29 respirator protection, PPE, vaccine risk, and "Constitutional Oath Accountability." (Ex. 108 at 1;  
30 Tr. IV at 13.)  
31

32  
33  
34           <sup>33</sup> The following exchange occurred at hearing:  
35

36           ALJ: [W]hen you are talking about something being effective or something  
37 working, are you talking about — would the standard be blocking all  
38 transmission of the particles that we are talking about?  
39

40           DR. STERN: Yeah. So the system we designed filters out 99.999996 percent of  
41 all particles 10 nanometers in size and larger[,] so 1/12 the size of the virus.  
42 That's what I determine is effective or how I would define effective control. I  
43 would be comfortable wearing.  
44

45           (Tr. IV at 190.)  
46

<sup>34</sup> At hearing, Ms. Kelly described Industrial Hygiene as "basically the field of anticipating, recognizing, and evaluating controls for health hazards in occupational settings." (Tr. IV at 13.)

111. In 2014, Ms. Kelly obtained a Bachelor of Science degree in Occupational Safety and Health and in 2017, she obtained a Master's Degree in Occupational Safety and Health from Columbia Southern University. She has received job training on topics such as hazardous waste operations, hazardous materials awareness, OSHA<sup>35</sup> supervisor and construction safety, bioenvironmental engineering, advanced industrial hygiene measurements, emergency response operations, the OSHA Voluntary Protection Program, industrial and administrative ergonomics, and FEMA Incident Command System and Response Plan. She has obtained certificates in Industrial Hygiene Management, Occupational Safety and Health, and Public Health. (Ex. R108 at 1-3.)

112. From November 2012 to 2016, Ms. Kelly worked as a Senior Industrial Hygienist for Commonwealth Edison/Exelon, the largest electrical utility company in Illinois. She managed Industrial Hygiene programs for approximately 6,000 employees; conducted inspections, risk assessments, and field health and safety audits to mitigate and/or control industrial hygiene and safety hazards; oversaw industrial hygiene and environmental contracts; approved sampling strategies; interpreted quantitative and qualitative data; facilitated accident and mishap investigations; approved cost proposals; and developed and presented formal training and instructional sessions. She specialized in reasonable accommodations in the workplace as related to safety and health issues, working with both Human Resources and union personnel to accommodate workers with disabilities and religious restrictions/needs. (Ex. R108 at 1.)

113. From 2001 to May 2012, Ms. Kelly worked as an Industrial Hygienist, Environmental Manager, and Construction Safety Officer for the Jesse Brown VA Medical Center. She managed Hearing Conservation, Confined Space, Blood-Borne Pathogen, and Ergonomics surveillance programs for more than 2,400 employees; managed and implemented OSHA's Respiratory Protection Program; oversaw construction projects; facilitated project modifications and provided risk assessment data during project development and implementation; repaired major program deficiencies in the Respiratory Protection Program; responded to and investigated OSHA/EPA inquiries; presented formal training and instructional sessions; supervised employee/contractor safety training; implemented Environmental Safety & Occupational Health Policies within the VA network; responded to indoor air quality issues, unknown odors, and potential gas leaks; chaired the Hazardous Materials/Environmental Committee and the Laser Safety Committee; and served as a member of the Medical Executive, Safety, and Infection Control Committees. (Ex. R108 at 1-2.)

114. From 2002 to 2010, Ms. Kelly worked as an Industrial Hygienist, Environmental Specialist, Emergency Responder, and Training Manager as an Active-Duty Member of the U.S. Air Force. (Ex. R108 at 2-3; Tr. IV at 13.) She conducted occupational health surveillance, radiological monitoring, and environmental surveys for 80,000 military and civilian workers at 700 workplaces; evaluated, sampled, and implemented control measures for cadmium, lead, asbestos, and strontium chromates; created training initiatives and employee education specific to employees' work areas; calibrated, operated, and utilized a wide variety of industrial hygiene and environmental sampling devices; assessed work area tasks and processes for worker health hazards; ensured safety programs were correct and control measures were adequate; provided

<sup>35</sup> This Final Order refers to the U.S. Occupational Safety and Health Administration as "OSHA," and the Oregon Occupational Safety and Health Division as "OR-OSHA."



1 guidance in selecting PPE; detected violations of published health standards/regulations and  
2 made corrective recommendations; tracked and managed workplace exposures; and performed  
3 environmental compliance sampling for proper waste disposal and safe drinking water. (Ex.  
4 R108 at 2-3.)  
5

6 115. Per federal OSHA regulations,<sup>36</sup> a health risk assessment must be conducted for  
7 each task and workplace before a conclusion may be reached that PPE, such as respiratory  
8 protection, is required in a workplace setting. (Tr. IV at 15-16, 23.)  
9

10 116. An industrial hygienist's goal is to find the safest and most effective way to protect  
11 an employee, with consideration of other available controls. (See Tr. IV at 54-55.) When  
12 selecting any form of PPE, an industrial hygienist considers both the effectiveness of the PPE  
13 and the safety of the PPE for the specific conditions, given the parameters of its use (*e.g.*,  
14 duration it will be worn; whether it can be changed out; the likelihood of cross-contamination).  
15 (*Id.* at 19, 23.)  
16

17 117. When an industrial hygienist performs pandemic planning, workers are placed into  
18 tiered exposure groups. N95 masks could, for example, be appropriate for workers in nutritional  
19 services or registration, but PAPRs and CAPRs would be required for workers with close  
20 contacts — such as surgeons operating on infectious patients. (Tr. IV at 28.)  
21

22 118. In Ms. Kelly's opinion, if an industrial hygienist ever approved or recommended  
23 the use of cloth masks, surgical masks, or ear loop masks as a form of source control or  
24 respiratory protection for the wearer against infectious diseases, the industrial hygienist would  
25 "probably be fined by OSHA, written up, and \* \* \* lose \* \* \* credentialing[.]" (Tr. IV at 25.) In  
26 her opinion, CDC guidance and state-level guidance/requirements pertaining to mask wearing for  
27 the COVID-19 pandemic contravene existing OSHA practices and standards. (*Id.*)  
28

29 119. In Ms. Kelly's opinion, there are no reliable scientific studies to date that support  
30 the efficacy of masks in curtailing the spread of viruses. (Tr. IV at 70.) When dealing with  
31 certain unnamed infectious diseases in healthcare settings, in Ms. Kelly's experience, Air Force  
32 healthcare workers did not wear N95 masks "due to the micron size of some of these viruses."  
33 (*Id.* at 18.) Instead, the workers wore respiratory protection devices such as PAPRs and  
34 controlled air purifying respirators (CAPRs). (*Id.*) In Ms. Kelly's opinion, PAPRs and CAPRs  
35 are considered the "top-tier selection" for respiratory protection in infectious disease wards.<sup>37</sup>  
36 (*Id.* at 27.) In Ms. Kelly's opinion, N95 masks "cannot filter aerosols at a safe level to where  
37 you have the most confidence as a control." (*Id.* at 26.)  
38

39 120. In Ms. Kelly's opinion, surgical and cloth masks have not been historically used as  
40 respirators. In her opinion, surgical masks have been viewed historically only as source control  
41

42 <sup>36</sup> At hearing, Ms. Kelly testified as to various federal standards in OSHA's respiratory protection program; her  
43 experience implementing such standards as an industrial hygienist; the regulatory requirements for initial and annual  
44 medical questionnaires; and the training requirements related to storage, cleaning, and usage of personal protective  
45 devices. (See Tr. IV at 14-18, 23.)

46 <sup>37</sup> Ms. Kelly testified that a PAPR can range in cost from approximately \$1,100 to \$2,000, and a single N95 mask  
might cost around \$50. (Tr. IV at 66.)

1 during surgeries to keep large droplets such as spit out of surgical wound sites. (Tr. IV at 28.) In  
2 Ms. Kelly's opinion, a typical surgical mask can only stop large droplets. (*Id.* at 56.)  
3

4 121. In Ms. Kelly's opinion, cloth contamination and self-contamination are significant  
5 factors in the failure of cloth and surgical masks to prevent or contain the spread of SARS-CoV-  
6 2. (Tr. IV at 32-33.) She believes that because, generally speaking, members of the public are  
7 not trained on how to properly don and doff such masks, when to change them out, and how to  
8 dispose of them properly, mask wearing provides people with a false sense of security as to  
9 masking's efficacy in mitigating the spread of SARS-CoV-2. (*Id.* at 33.)  
10

11 122. In Ms. Kelly's opinion, allowing patients to choose whether to wear a mask in a  
12 healthcare setting "respects a multitude of issues with medical intolerance and individual ADA  
13 disabilities where some people cannot don a mask." (Tr. IV at 35.)  
14

### 15 **Relevant Medical Literature**

16

17 123. The peer-reviewed journal *Travel Medicine and Infectious Disease* published an  
18 article in May 2020, titled "Efficacy of face mask in preventing respiratory virus transmission:  
19 A systematic review of meta-analysis." (*See* Ex. A11 at 2-10; Tr. I at 127-129.) The systematic  
20 review and meta-analysis consisted of 21 studies and almost 9,000 participants. It included 13  
21 case-control studies, 2 cohort studies, and six cluster randomized trials—seven involving SARS,  
22 five involving H1N1, four involving influenza virus, four involving respiratory viral illness, and  
23 one involving SARS-CoV-2. It considered face mask use in both healthcare workers and non-  
24 healthcare workers. (Ex. A11 at 4-5; Tr. I at 127-129.) In Dr. Sutton's opinion, all of the data  
25 "best practices" for performing systematic reviews and meta-analyses were followed. (Tr. I at  
26 127.) The meta-analyses of the 21 studies demonstrated that masking reduced the overall risk of  
27 respiratory virus transmission by 65 percent, with an 80 percent reduction for health care  
28 workers and a 47 percent reduction for non-healthcare workers. (*See* Ex. A11 at 2-8; Tr. I at  
29 128.) The results suggest that mask use provided "a significant protective effect" on the spread  
30 of respiratory viruses. (Ex. A11 at 2.) The authors concluded that while more evidence is still  
31 needed to better clarify the effectiveness of masking in various circumstances, the systematic  
32 review and meta-analysis "showed the general efficacy of masks in preventing the transmission"  
33 of respiratory viral illness. (*Id.* at 8.)  
34

35 124. *The Lancet*, a widely recognized and respected journal in science and health,  
36 published "Physical distancing, face masks, and eye protection to prevent person-to-person  
37 transmission of SARS-CoV-2 and COVID-19: a systematic review and meta-analysis" on June  
38 27, 2020. (Ex. R77 at 1-15; Tr. II at 185-186.) This systematic review and meta-analysis looked  
39 at 172 observational studies across 16 countries and 44 comparative studies in healthcare and  
40 non-healthcare settings, including 29 studies specific to mask-wearing, involving SARS-CoV-2,  
41 SARS-CoV, and MERS-CoV. (Ex. R77 at 1-2, 7; Tr. II at 186.) The results "suggest that  
42 wearing face masks protects people (both health-care workers and the general public) against  
43 infection by these coronaviruses." (Ex. R77 at 10.) The authors concluded that findings  
44 "continued to support the ideas not only that masks in general are associated with a large  
45 reduction in risk of infection from SARS-CoV-2, SARS-CoV, and MERS-CoV but also that N95  
46 ///

1 or similar respirators might be associated with a larger degree of protection from viral infection  
2 than disposable medical masks or reusable multilayer (12-16-layer) cotton masks. (*Id.*)  
3

4 125. *The Lancet* published a written commentary from C. Raina MacIntyre, who is well-  
5 respected in the field of masking and infectious diseases, on June 1, 2020, titled “Physical  
6 distancing, face masks, and eye protection for prevention of COVID-19.”<sup>38</sup> (Ex. R76 at 1-2; Tr.  
7 II at 194.) The commentary focuses on the June 27, 2020 systematic review and meta-analysis,  
8 which has been designated as Exhibit R77. (Tr. II at 194-195.) Dr. MacIntyre notes that the  
9 results of the systematic review and meta-analysis support universal face mask use “because  
10 masks were equally effective in both health-care and community settings when adjusted for type  
11 of mask use.” (Ex. R76 at 2.) Dr. MacIntyre also notes that “[g]rowing evidence” of  
12 presymptomatic and asymptomatic transmission of SARS-CoV-21 provides further support for  
13 both universal face mask use and distancing. (*Id.*) Dr. MacIntyre concluded that “[u]ntil  
14 randomised controlled trial data are available, this study provides the best specific evidence for  
15 COVID-19 prevention.” (*Id.*)  
16

17 126. *Acta Informatica Medica* published an article (“Professional Paper”) on September  
18 22, 2008, titled “Evidence Based Medicine – New Approaches and Challenges.” (Ex. R43 at 1-  
19 7; Tr. IV at 198.) The author states, in part:  
20

21 One of the greatest achievements of evidence-based medicine has been the  
22 development of systematic reviews and meta-analyses, methods by which  
23 researchers identify multiple studies on a topic, separate the best ones and  
24 then critically analyze them to come up with a summary of the best  
25 available evidence.  
26

27 (Ex. R43 at 1.)  
28

29 127. *The Annals of Internal Medicine* published an article on June 24, 2020, titled  
30 “Masks for Prevention of Respiratory Virus Infections, Including SARS-CoV-2, in Health Care  
31 and Community Settings: A Living Rapid Review.” (Ex. R68 at 1-15; Tr. IV at 220-222.) The  
32 article examined the effectiveness of N95, surgical, and cloth masks in community and health  
33 care settings for preventing respiratory virus infections by reviewing 18 randomized controlled  
34 trials and 21 observational studies. (Ex. R68 at 1.) The evidence on SARS-CoV-2 was limited  
35 to 2 observational studies “with serious limitations.” (*Id.*) The authors found that community  
36 mask use was “possibly associated with decreased risk for SARS-CoV-1 infection in  
37 observational studies.” (*Id.*) In high- or moderate-risk health care settings, observational studies  
38 found that risk for infection with SARS-CoV-1 and MERS probably decreased with mask use  
39 versus nonuse and possibly decreased with N95 versus surgical mask use. The authors  
40 concluded that “[e]vidence on mask effectiveness for respiratory infection prevention is stronger  
41 in health care than community settings,” and while “N95 respirators might reduce SARS-CoV-1  
42 risk versus surgical masks in health care settings,” the applicability to SARS-CoV-2 is uncertain.  
43 (*Id.*)  
44  
45

46 <sup>38</sup> Dr. Nolt explained at hearing that for studies that seem quite seminal, frequently another expert (who is not affiliated with the study) will write a commentary highlighting the significance of the study. (Tr. II at 194.)

1           128. The *Proceedings of the National Academy of Sciences of the United States of*  
2 *America (PNAS)* published an article in January 2021 (submitted for review in July 2020), titled  
3 “An Evidence Review of Face Masks Against COVID-19.” (See Ex. A13 at 1; Tr. II at 35-36.)  
4 The authors conducted a narrative review of mask usage, and synthesized the relevant literature  
5 with regard to multiple areas, including population impact, transmission characteristics, source  
6 control, wearer protection, sociological considerations, and implementation considerations. The  
7 authors noted that the primary route of COVID-19 transmission occurs via respiratory particles  
8 and the virus is known to be transmissible from presymptomatic, paucisymptomatic, and  
9 asymptomatic persons. The authors concluded that a preponderance of the evidence  
10 demonstrates that mask wearing “reduces transmissibility per contact by reducing transmission  
11 of infected respiratory particles in both laboratory and clinical contexts.” (See Ex. A13 at 1; Tr.  
12 II at 35-43.) The authors recommend that public official adopt masking mandates, reasoning that  
13 a masking mandate is not only more effective in generating mask use, but it is perceived as being  
14 more fair and socially responsible by the general public and reduces the stigma associated with  
15 wearing a mask. (Tr. II at 42-43.)  
16

17           129. *Lancet Respiratory Medicine* published an article by Kevin P. Fennelly, M.D.,<sup>39</sup> on  
18 July 24, 2020, titled, “Particle sizes of infectious aerosols: implications for infectious control.”  
19 (Ex. R103; Tr. IV at 30-31.) The author reviewed the scientific literature on the aerosols  
20 generated by persons with respiratory infections and discussed how such data might inform the  
21 optimal use of masks, respirators, and other measures to protect healthcare workers. (Ex. R103  
22 at 1.) The author determined there is “no evidence to support the concept that most respiratory  
23 infections are associated with primary large droplet transmission. In fact, small particle aerosols  
24 are the rule, rather than the exception.” (R103 at 7; Tr. IV at 31.) With regard to SARS-CoV-2  
25 specifically, the author concluded that the virus “has the potential to be spread by all modes of  
26 transmission: direct contact (i.e., person-to-person) and indirect contact (e.g., via contaminated  
27 objects and aerosol)” but it “is not yet clear which mode occurs most frequently.” (Ex. R103 at  
28 6.) The author noted that “[t]here is mounting evidence suggesting that the wearing of masks  
29 can reduce transmission of SARS-CoV-2 in community and health-care settings.” (*Id.* at 8.) The  
30 author concluded that, with regard to infectious aerosols in general, “[s]urgical masks might  
31 offer some respiratory protection from inhalation of infectious aerosols, but not as much as  
32 respirators. However, surgical masks worn by patients reduce exposures to infectious aerosols to  
33 health-care workers and other individuals.” (*Id.* at 2.)  
34

35           130. The *American Society for Microbiology (mSphere)* published a study in October  
36 2020, titled “Effectiveness of Face Masks in Preventing Airborne Transmission of SARS-CoV-  
37 2.” (See Ex. A11 at 25-29; Tr. II at 30-34.) Using an airborne transmission simulator (and  
38 mannequins), and a “relatively high dose of virus,” the study assessed the transmissibility of  
39 infectious droplets/aerosols of SARS-CoV-2 and the ability of cotton, surgical, and N95 masks  
40 to block the transmission. (Ex. A11 at 25, 29; Tr. II at 30-31.) The simulations showed that  
41 “cotton masks, surgical marks, and N95 masks had a protective effect with respect to the  
42 transmission of infective droplets/aerosols and that the protective efficiency was higher when  
43 masks were worn by the virus spreader.”<sup>40</sup> (Ex. A11 at 25, 27; Tr. II at 33.) The study also  
44

45           <sup>39</sup> Dr. Fennelly is with the Pulmonary Branch of the NIH’s Division of Intramural Research, National  
46 Heart, Lung, and Blood Institute. (Ex. R103 at 1.)

<sup>40</sup> N95 masks demonstrated the highest protective efficiency. (Ex. A11 at 27.)

1 found a “synergistic effect” when both the virus spreader and virus receiver wore cotton or  
2 surgical masks. (Ex. A11 at 27; Tr. II at 33-34.) Dr. Farris believes that the study likely  
3 underestimated the effectiveness of the masks because the study used a relatively thin non-  
4 physiologic fluid and a continuous stream of gas through the source mask that was intended to  
5 mimic normal, mild, and moderate coughing for 20 minutes at the point of measurement. Dr.  
6 Farris opined:

7  
8 I don’t want to contemplate [coughing] continuously for 20 minutes  
9 because it sounds like I would die, but that is the model that they used; so  
10 I find it not the least bit surprising that they measured a relatively low,  
11 compared to other epidemiologic studies, \* \* \* success rate for these  
12 masks. I believe that they did that to try overwhelm the masks and \* \* \*  
13 basically test their breaking point. Twenty minutes of a continuous stream  
14 of a non-protein containing fluid, a relatively thin fluid in other words,  
15 would basically stress any mask to the breaking point. So if you still find  
16 a 20 percent containment at that point with even a cloth mask, it stands to  
17 reason that you are going to find a significantly higher rate of containment  
18 in someone who is speaking or coughing, even saying the word healthy.

19  
20 (Tr. II at 32-33.)  
21

22 131. The peer-reviewed journal *Annals of Internal Medicine* published a study in  
23 November 2020, titled “Effectiveness of Adding a Mask Recommendation to Other Public  
24 Health Measures to Prevent SARS-CoV-2 Infection in Danish Mask Wearers: A Randomized  
25 Controlled Trial” (the Danish Study). (Ex. A6; Tr. III at 24; Tr. II at 25-27.) The Danish Study  
26 is the only randomized controlled trial specifically pertaining to SARS-CoV-2. (Tr. III at 25-26.)  
27 The study sought to determine whether recommending surgical mask use outside of the home  
28 reduced the wearers’ risk for SARS-CoV-2 infection in a setting where masks were uncommon  
29 and were not a recommended health measure. The participants were comprised of adults who  
30 spent more than three hours per day outside of the household. They were encouraged to follow  
31 social distancing measures, plus either a no-mask recommendation or a recommendation to wear  
32 a surgical mask when outside the home among other persons. (Ex. R6 at 1.) The results showed  
33 that out of 4,862 participants who completed the study, SARS-CoV-2 infection occurred in 42  
34 participants for whom masks had been recommended and in 53 participants in the non-mask  
35 recommended control group. (*Id.* at 2.) The authors noted the following limitations of the study:  
36 “Inconclusive results, missing data, variable adherence, patient-reported findings on home tests,  
37 no blinding, and no assessment of whether masks could decrease disease transmission from mask  
38 wearers to others.” (*Id.*) The authors concluded that the recommendation to wear surgical masks  
39 as an adjunctive public health measure did not reduce the SARS-CoV-2 infection rate among the  
40 study participants by more than 50 percent in a community with modest infection rates, some  
41 social distancing, and uncommon general mask use. (*Id.*) The authors noted, however, that the  
42 study findings should not be used to conclude that a recommendation for everyone to wear  
43 masks in the community would not be effective in reducing SARS-CoV-2 infections. (*See* Tr. I  
44 at 155.)

45  
46 ///

1           132. In Dr. Sutton's opinion, the Danish study is a "really nice example of why a  
2 randomized controlled trial is not always perfect despite being considered the gold standard and  
3 how they can fail." (Tr. I at 153.) In her opinion, the issue with the study is that "compliance  
4 with the interventions was very low." (*Id.* at 154.) Only 46 percent of the study subjects  
5 reporting wearing the mask as recommended, and 47 percent reported wearing it as  
6 predominantly recommended. (*Id.* at 154, 219.) In addition, 20 percent of the participants  
7 dropped out of the study. In Dr. Sutton's opinion, that is a high drop-out rate. (*Id.* at 154-155.)  
8 In Dr. Sutton's opinion, the study was not designed to determine the effectiveness of source  
9 control. Rather, the study was confined to testing the protective effect of masking, and it failed  
10 to reliably test that due to poor participant compliance. (*Id.* at 155.)  
11

12           133. Dr. Farris believes that one limitation of the Danish study is that it did not measure  
13 the spread of disease from people wearing masks (*i.e.*, source containment or spreader effect),  
14 which other studies have shown to be the primary role of masks in preventing SARS-CoV-2  
15 contagion. (Tr. II at 25, 27.) In Dr. Farris' opinion, instructing 3,000 people to wear masks as  
16 opposed to not instructing them to "was a pretty weak intervention," with no mechanism to  
17 reliably measure compliance. (*Id.* at 26.) In Dr. Farris' opinion, although the study failed to  
18 demonstrate that masking reduced the SARS-CoV-2 infection rate among the study participants  
19 by more than 50 percent in their particular community, the study did not conclude that masking  
20 is ineffective. (*Id.* at 25.) Dr. Farris believes the study demonstrated some effect from wearing  
21 masks in the current pandemic, and he opines as follows:  
22

23           What is done in virtually all scientific experiments is a statistical analysis  
24 to try to estimate the likelihood that \* \* \* [any] measured difference was  
25 \* \* \* purely due to random fluctuation as opposed to a real effect.  
26

27           [Here,] the statistical analyses, one showed about a 30 percent likelihood  
28 that it was due to a random effect, and \* \* \* the other was 34 percent.  
29 That certainly does not pass scientific rigor.  
30

31           The generally accepted cutoff for scientific rigor is about a 5 percent  
32 chance or less that the effect measured was due to random variation. So  
33 you will see P values in virtually every scientific study, and a P of less  
34 than 0.05 or 5 percent is the standard scientific cutoff.  
35

36           You will see some studies where the P value is shown at less than 0.001.  
37 In other words, the chance of that being due to a random fluctuation is  
38 something like one in 10,000[.]  
39

40           [Here,] that P value of 0.3 or 0.34 states that the statistical analyses show  
41 that the likelihood that this was due to a random set of fluctuations was 30  
42 percent or 34 percent, meaning that the likelihood that the effect was real  
43 was either 70 percent or 66 percent. So I'm not sure if 70 percent or 66  
44 percent passes the legal muster of the preponderance of the evidence, but  
45 it does state that it is more likely than it is less likely that even that small  
46 effect was real.

1  
2 So to interpret that study as being that it shows no effect for masks is just  
3 patently wrong. First of all, the study was not designed to show that, and  
4 it did not measure what is generally assumed to be or generally shown to  
5 be the predominant effect of masks, and that is \* \* \* source containment.  
6

7 (*Id.* at 25-27.) In Licensee's opinion, the Danish Study came to "the exact same conclusion" as  
8 17 randomized controlled studies regarding influenza or influenza-like illness — that masks have  
9 "very little or no benefit whatsoever in containing the spread of Coronavirus or influenza." (*See*  
10 Tr. III at 26, 28.)  
11

12 134. *PNAS* published an article on June 30, 2020, titled "Identifying airborne  
13 transmission as the dominant route for the spread of COVID-19." (Ex. R17<sup>41</sup> at 1-21.) The  
14 authors state, in part:  
15

16 Here we show that airborne transmission is highly virulent and represents  
17 the dominant route to spread the disease.  
18

19 We conclude that wearing of face masks in public corresponds to the most  
20 effective means to prevent interhuman transmission, and this inexpensive  
21 practice, in conjunction with simultaneous social distancing, quarantine,  
22 and contact tracing, represents the most likely fighting opportunity to stop  
23 the COVID-19 pandemic.  
24

25 (*Id.* at 2.) Dr. Stern disagrees with the above conclusion. (*See* Tr. IV at 240.)  
26

27 135. *JAMA* published an article on February 10, 2021, titled "Effectiveness of Mask  
28 Wearing to Control Community Spread of SARS-CoV-2." (Ex. A15 at 1-2.) The authors note  
29 that an estimated 50 percent or more of SARS-CoV-2 transmissions "are from persons who  
30 never develop symptoms or those who are in the presymptomatic phase of COVID-19 illness."  
31 (*Id.* at 1.) The authors also note that "[c]oncerns about reduced oxygen saturation and carbon  
32 dioxide retention when wearing a mask have not been supported by available data." (*Id.*) The  
33 authors opine that the Danish Study "has been improperly characterized by some sources as  
34 showing that cloth and surgical masks offer no benefit." (*Id.*) The authors explain:  
35

36 This randomized trial in Denmark was designed to detect at least a 50%  
37 reduction in risk for persons wearing surgical masks. Findings were  
38 inconclusive, most likely because the actual reduction in exposure these  
39 masks provided for the wearer was lower. More importantly, the study  
40 was far too small (*i.e.*, enrolled about 0.1% of the population) to assess  
41 the community benefit achieved when wearer protection is combined  
42 with reduced source transmission from mask wearers to others.  
43

44 (*Id.*) The authors determine that "[c]ompelling data now demonstrate that community mask  
45 wearing is an effective nonpharmacological intervention to reduce the spread of this infection,  
46

<sup>41</sup> Exhibit R17 is a duplicate of Exhibit R38.

1 especially as source control to prevent spread from infected persons, but also as protection to  
2 reduce wearers' exposure to infection." (*Id.*)  
3

4 136. *Nature Communications*, a peer-reviewed journal, published a study on November  
5 20, 2020, titled "Post-lockdown SARS-CoV-2 nucleic acid screening in nearly 10 million  
6 residents in Wuhan, China" (Wuhan study). (Ex. R13 at 1-7.) The study looked at the  
7 prevalence of SARS-CoV-2 infection following the release of stringent COVID-19 control  
8 measures in Wuhan, China. Nearly 10 million residents participated in the study. The results  
9 showed no new symptomatic cases and 300 asymptomatic cases, with no positive tests among  
10 1,174 close contacts of asymptomatic cases. (*Id.* at 1; Tr. I at 197-198.) The authors  
11 summarized the study as follows:  
12

13 The detection rate of asymptomatic positive cases in the post-lockdown  
14 Wuhan was very low (0.303/10,000), and there was no evidence that the  
15 identified asymptomatic positive cases were infectious. These findings  
16 enabled decision makers to adjust prevention and control strategies in the  
17 post-lockdown period. Further studies are required to fully evaluate the  
18 impacts and cost-effectiveness of the citywide screening of SARS-CoV-2  
19 infections on population's health, health behaviors, economy, and society.  
20

21 (Ex. A13 at 6.) In Licensee's opinion, the Wuhan study supports his position that asymptomatic  
22 spread of SARS-CoV-2 is not significant. (Tr. V at 9; *see also* Tr. I at 103.) And, he believes  
23 that the Wuhan study is supported by other studies showing that the spread of COVID-19 from  
24 asymptomatic patients "appears to be absolutely insignificant." (Tr. I at 103.) In Dr. Sutton's  
25 opinion, the Wuhan study does not persuasively bolster Licensee's position regarding a lack of  
26 asymptomatic spread of SARS-CoV-2. She believes that the primary takeaway from the Wuhan  
27 study is that the lockdown and masking policy were very effective. In Dr. Sutton's opinion, her  
28 takeaway is consistent with the authors' conclusion, which was that the prevalence of SARS-  
29 CoV-2 infection in Wuhan was very low five to eight weeks after a period of lockdown. (*Id.* at  
30 197-198; *see* Ex. R13 at 1.)  
31

32 137. The *New England Journal of Medicine* published a letter on April 15, 2020, titled  
33 "Visualizing Speech-Generated Oral Fluid Droplets with Laser Light Scattering." (Ex. A15 at 3-  
34 4; Tr. II at 28-30.) The letter discussed a study demonstrating, through a laser light scattering  
35 simulation, visual evidence of the droplets created through normal speech, both with and without  
36 the use of a crude mask (*i.e.*, a damp washcloth held in place with rubber bands). (Ex. A15 at 3-  
37 4; Tr. II at 28-30.) The study showed, among other things, that wearing the crude mask while  
38 speaking decreased the number of forward-moving droplets. (*See* Ex. A15 at 4.) In Dr. Farris'  
39 opinion, the laser light scattering study is "absolutely demonstrative of the effects of masks."  
40 (Tr. II at 29.)  
41

42 138. The journal *PLOS One* published an article on February 24, 2021, titled "The  
43 effects of wearing facemasks on oxygenation and ventilation at rest and during physical  
44 activity." (Ex. A22 at 1-7; Tr. I at 152-153.) The study assessed whether either cloth masks or  
45 surgical masks impaired oxygenation or ventilation, at rest or during physical activity  
46 (specifically, 10 minutes of brisk walking). The results showed that among the 50 adult hospital



1 employee volunteers (32 percent of whom had a significant co-morbidity),<sup>42</sup> there were “no  
2 episodes” of hypoxemia (*i.e.*, low oxygen level) or hypercarbia (*i.e.*, increased CO2 level). (Ex.  
3 A22 at 1-2, 4; Tr. I at 152-153.) The authors concluded that “[t]he risk of pathologic gas  
4 exchange impairment with cloth masks and surgical masks is near-zero in the general adult  
5 population.” (Ex. A22 at 2; Tr. I at 152-153.) The authors noted several prior studies of smaller  
6 cohorts that similarly found that surgical masks “cause statistically insignificant or clinically  
7 insignificant effects on heart rate and gas exchange.” (Ex. A22 at 5; internal citations omitted.)  
8

9 139. *The Annals of the American Thoracic Society* published a study titled, “Effect of  
10 Face Masks on Gas Exchange in Healthy Persons and Patients with Chronic Obstructive  
11 Pulmonary Disease,” which involved 15 healthy physicians and 15 patients with severe chronic  
12 obstructive pulmonary disease (COPD). (Tr. I at 145-147.) In the study, markers of respiration  
13 were measured at baseline, resting with no mask, after masking and sitting for five minutes at  
14 rest, after sitting for 30 minutes at rest, and then before and after a “six-minute walk test.” (*Id.* at  
15 146.) The study showed that, as measured by oxygen and carbon dioxide levels, masking did not  
16 affect respiration in either the 15 health physicians or the 15 patients with severe COPD. (*Id.*)  
17

18 140. The journal *Respiratory Physiology and Neurobiology* published a January 24, 2012  
19 article titled “Absence of consequential changes in physiological, thermal and subjective  
20 responses from wearing a surgical mask.” (Ex. A12 at 1-7; Tr. I at 145-146.) The study  
21 consisted of 20 healthy people who exercised at a low-moderate rate on a treadmill for one hour,  
22 with and without a mask, while being monitored for heart rate, respiratory rate, oxygen  
23 saturation, transcutaneous CO2, SpO2, core and skin temperatures, mask deadspace heat and  
24 relative humidity, and skin temperature under the mask. The results showed that surgical mask  
25 use for one hour at a low-moderate work rate was “not associated with clinically significant  
26 physiological impact or significant subjective perceptions of exertion and heat.” (Ex. A12 at 1-4;  
27 Tr. I at 146-147.) The authors concluded that any intolerance to wearing surgical mask “is not  
28 likely related to an increased physiological burden, but may reflect [surgical mask]-related  
29 neurological or physiological effects.” (Ex. A12 at 6.)  
30

31 141. The *Journal of Cardiopulmonary Rehabilitation and Prevention* published an  
32 article on January 1, 2021 titled, “The Physiological Impact of Masking is Insignificant and  
33 Should Not Preclude Routine Use During Daily Activities, Exercise, and Rehabilitation.” (Ex.  
34 A13 at 1-2; Tr. II at 45-46.) The authors concluded that masking during daily activities,  
35 exercise, and rehabilitation is safe for healthy individuals, as well as for individuals with  
36 underlying cardiopulmonary disease, and determined that the benefits of masking during the  
37 COVID-19 pandemic “far outweigh the risks, and increased frequency of mask use invokes  
38 adaptive responses that make long-term masking tolerable.” (Ex. A13 at 2; Tr. II at 45-46.)  
39

40 142. *Scientific Reports*, a peer-reviewed journal, published an article on September 10,  
41 2018, titled “Hypercapnia Alters Expression of Immune Response, Nucleosome Assembly and  
42 Lipid Metabolism Genes in Differentiated Human Bronchial Epithelial Cells.” (Ex. R29 at 1-11;  
43 Tr. II at 23-24.) Hypercapnia refers to excessive CO2. (Tr. II at 23.) The authors measured the  
44 changes in gene expression in cell culture by taking cells from the airway epithelium and  
45 exposing the cells to 20 percent CO2 versus normal, which is five percent. (Ex. R29 at 1-2; Tr.  
46

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<sup>42</sup> For example, six study participants had asthma and four study participants had hypertension. (Ex. A22 at 3.)

II at 24.) In Dr. Farris' opinion, 20 percent CO2 corresponds to a level of CO2 achievable in the human body "by holding one's breath for about two hours," which he posits is not possible. (Tr. II at 24.) In Dr. Farris' opinion, the study measured gene expression in the bronchial epithelial cells "at an absolutely extraordinary level" of CO2, and he therefore finds "no relevance whatsoever in terms of the question of masking." (*Id.*; *see also id.* at 77.)

143. The *MMWR*, an epidemiological digest published by the CDC, published a July 17, 2020 article titled "Absence of Apparent Transmission of SARS-CoV-2 from Two Stylists After Exposure at a Hair Salon with a Universal Face Covering Policy—Springfield, Missouri, May 2020." (Ex. A25 at 1-3; Tr. I at 125-126.) The article discussed a public health investigation that revealed no signs of COVID-19 transmission to 139 exposed hair salon clients by two salon hair stylists infected with COVID-19. The two stylists and all 139 clients had worn masks during the exposures, which ranged in duration from 15 to 45 minutes. Stylist A had worked with clients for eight days while symptomatic (but before testing positive for COVID-19) and wore a double-layer cotton face covering each of those days during client encounters. Stylist B worked with clients for five days while symptomatic (but before testing positive) and wore either a double-layer cotton mask or a surgical mask during her client encounters. The 139 clients wore either cloth face coverings, surgical masks, or N95 respirators. Contact tracing occurred for all 139 exposed clients, and none of the clients reported any signs or symptoms of COVID-19 for 14 days after their last salon exposure. Out of a total of 67 exposed clients who volunteered to be COVID-19 tested at least five days after their last exposure, all 67 tested negative for SARS-CoV-2. All four of Stylist A's close contacts identified for contact tracing purposes (her cohabitating husband; and her daughter, son-in-law, and their roommate who lived together in another household) all subsequently developed symptoms and tested positive for SARS-CoV-2. (Ex. A25 at 1-2; Tr. I at 125-126.) The authors of the article concluded that the findings support the role of source control in preventing COVID-19 transmission and can inform the development of public health policy during the pandemic. (Ex. A25 at 1.)

144. *Scientific Reports* published a study on September 24, 2020, titled "Efficacy of masks and face coverings in controlling outward aerosol particle emission from expiratory activities." (Ex. R67 at 1-13; Tr. IV at 211-213.) The study is summarized, in relevant part, as follows:

[W]e measured outward emissions of micron-scale aerosol particles by healthy humans performing various expiratory activities while wearing different types of medical-grade or homemade masks. *Both surgical masks and unvented KN95 respirators, even without fit-testing, reduce the outward particle emission rates by 90% and 74% on average during speaking and coughing, respectively, compared to wearing no mask, corroborating their effectiveness at reducing outward emission. \* \* \* \* \**

Further work is needed to establish the efficacy of cloth masks at blocking expiratory particles for speech and coughing at varied intensity and to assess whether virus-contaminated fabrics can generate aerosolized fomites, but the results strongly corroborate the efficacy of medical-grade

///

1 masks and highlight the importance of regular washing of homemade  
2 masks.

3  
4 \* \* \* \* \*

5  
6 While the efficacy of cloth and paper masks is not as clear and  
7 confounded by shedding of mask fibers, the observations indicate it is  
8 likely that they provide some reductions in emitted expiratory particles, in  
9 particular the larger particles ( $> 0.5 \mu\text{m}$ ). We have not directly measured  
10 virus emission; nonetheless, our results strongly imply that mask wearing  
11 will reduce emission of virus-laden aerosols and droplets associated with  
12 expiratory activities, unless appreciable shedding of viable viruses on  
13 mask fibers occurs. The majority of the particles emitted were in the  
14 aerosol range ( $< 5 \mu\text{m}$ ). \* \* \*. Our observations are consistent with  
15 suggestions that mask wearing can help in mitigating pandemics  
16 associated with respiratory disease[.]

17  
18 (Ex. R67 at 1; italicized emphasis added.) In Dr. Stern's opinion, this study is strong evidence  
19 that people should not be wearing cloth masks during the Covid-19 pandemic. (Tr. IV at 211-  
20 213; *see* Ex. R67.) In his opinion, the study showed that, with respect to porous cotton masks,  
21 "if you take fluid and you force it through the mask, you take big particles and make them small  
22 particles. You increase the count of respirable particles. You turn people into sprinklers and so  
23 if someone has COVID and they are wearing a cloth mask, they are increasing their respirable  
24 particles when they cough which is very concerning." (Tr. IV at 212-213; *see also id.* at 184.)  
25 Dr. Stern disagrees with the conclusion that mask wearing can help in mitigating pandemics  
26 involving respiratory disease. (*See* Tr. IV at 252-253.)

27  
28 145. *MMWR* published a June 12, 2020 article titled "SARS-CoV-2 Infection and  
29 Serologic Responses from a Sample of U.S. Navy Service Members — USS Theodore  
30 Roosevelt, April 2020." (Ex. A11 at 13-24; Tr. I at 130.) The article discusses a COVID-19  
31 outbreak aboard a Navy vessel that was subsequently investigated by the Navy and the CDC.  
32 (Ex. A11 at 13; Tr. I at 130-131.) The investigation involved having 382 of the 1,417 service  
33 members involved in the outbreak fill out a questionnaire regarding demographic characteristics,  
34 exposure, COVID-19 protective behaviors, health history, and symptoms. Masking, with self-  
35 reported use of face coverings, was associated with a 70 percent lower odds of infection in the  
36 study group. The limitations of the study include the small study size and the fact that  
37 information was obtained from the study subjects by self-report, raising the possibility of  
38 selection and recall bias. (Ex. A11 at 14-15; Tr. I at 131.) In Dr. Stern's opinion, there are many  
39 opportunities for bias in this study, as the authors could not control for social distancing or for  
40 different ventilation in various parts of the ship. (Tr. IV at 229.)

41  
42 146. *BMJ Open*, an online peer-reviewed medical journal, published a study on April 22,  
43 2015, titled "A cluster randomised trial of cloth masks compared with medical masks in  
44 healthcare workers." (Ex. R69 at 1-10; Tr. IV at 192-197.) This study aimed to determine the  
45 efficacy of cloth masks compared with medical masks in healthcare workers in high-risk hospital  
46 wards, against the prevention of respiratory infections. The study involved 1,600 people in 72  
wards over 14 hospitals. A cluster randomized design was utilized (with the hospital wards

1 serving as the clusters). The hospital wards were randomized to medical masks, cloth masks, or  
2 a control group (with subjects following their usual masking practices).<sup>43</sup> The main outcome  
3 measures pertained to clinical respiratory illness (CRI), influenza-like illness (ILI), and  
4 laboratory-confirmed respiratory virus infection (Ex. A69 at 1-2; Tr. IV at 193.) The rates of  
5 infection outcomes were highest in the cloth mask arm, with the rate of ILI statistically  
6 significantly higher in the cloth mask arm compared with the medical mask arm. Cloth masks  
7 also had significantly higher rates of ILI compared with the control arm. An analysis by mask  
8 use showed ILI and laboratory-confirmed virus were significantly higher in the cloth mask group  
9 compared with the medical mask group. The authors concluded that the results “caution against  
10 the use of cloth masks,” but they noted that “[f]urther research is needed to inform the  
11 widespread use of cloth masks globally.” (Ex. R69 at 1.) In Dr. Stern’s opinion, the study is  
12 “probably the highest quality clinical research on the use of masks in protecting people from  
13 respiratory viruses in the healthcare setting.” (Tr. IV at 193.) Dr. Stern found the study “quite  
14 alarming” when he originally read it. (*Id.* at 194.) In his opinion, the study shows that “not only  
15 do cloth masks not protect, they increase the likelihood you are going to get an infection if you  
16 wear them in a healthcare setting.” (*Id.* at 194.) However, with regard to various limitations of  
17 the study, the authors noted the following:

18  
19 [T]he control [healthcare workers] \* \* \* used medical masks more often  
20 than cloth masks.

21  
22 \* \* \* \* \*

23  
24 *The study design does not allow us to determine whether medical masks*  
25 *had efficacy or whether cloth masks were detrimental* to [healthcare  
26 workers] by causing an increase in infection risk. Either possibility, or a  
27 combination of both effects, could explain our results. It is also unknown  
28 whether the rates of infection observed in the cloth mask arm are the same  
29 or higher than in HCWs who do not wear a mask, as almost all  
30 participants in the control arm used a mask.

31  
32 \* \* \* \* \*

33  
34 [W]e did not measure compliance with hand hygiene, and the results  
35 reflect self-reported compliance, which may be subject to recall or other  
36 types of bias. Another limitation of this study is the lack of a no-mask  
37 control group and the high use of masks in the controls, which makes  
38 interpretation of the results more difficult.

39  
40 (Ex. R69 at 6-7; italicized emphasis added.)

41  
42 147. The *National Center for Biotechnology Information (NCBI)* published an article on  
43 October 4, 2020, titled “Features, Evaluation, and Treatment of Coronavirus.” (Ex. R40 at 1-30;  
44 Tr. IV at 180.) The article states, in part:

45  
46  

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43 It was deemed unethical to have a “no mask” control group. (Ex. R69 at 2.)

1 As with other respiratory pathogens, including flu and rhinovirus, the  
2 transmission is believed to occur through respiratory droplets (particles  
3 >5-10 µm in diameter) from coughing and sneezing. Aerosol transmission  
4 is also possible in case of protracted exposure to elevated aerosol  
5 concentrations in closed spaces. Analysis of data related to the spread of  
6 SARS-CoV-2 in China seems to indicate that close contact between  
7 individuals is necessary. Of note, pre- and asymptomatic individuals may  
8 contribute up to 80% of COVID-19 transmission.  
9

10 (Ex. R40 at 3.)  
11

12 148. The *British Medical Bulletin* published an article on December 15, 2020, titled  
13 “Narrative Review of Non-Pharmaceutical Behavioural Measures for the Prevention of COVID-  
14 19 (SARS-CoV-2) Based on the Health-EDRM Framework.” (See Ex. A13 at 1; Tr. II at 43-45.)  
15 The authors concluded that the quality level of evidence for ten non-pharmaceutical behavioral  
16 measures (including, for example, hand washing, crowd avoidance, and mask wearing) was  
17 relatively weak. (Tr. II at 43-44.)  
18

19 149. *The New England Journal of Medicine* published an article on December 17, 2020,  
20 titled, “SARS-CoV-2 Transmission among Marine Recruits during Quarantine.” (Ex. R23 at 1-  
21 10.<sup>44</sup>) The authors investigated SARS-CoV-2 infections among Marine recruits during a  
22 supervised two-week quarantine at a closed college campus. The results showed that  
23 transmission clusters occurred within platoons, that most recruits who ultimately tested positive  
24 were asymptomatic, and that the risk of virus transmission was increased in settings where mask  
25 use or proximity were not followed (among roommates and within platoons). (See Ex. R23 at 1,  
26 7-9.)  
27

28 150. *BMJ Global Health* published a narrative article on May 14, 2020, titled “Universal  
29 masking for COVID-19: evidence, ethics and recommendations.” (Ex. R66 at 1-6; Tr. II at 192-  
30 193.) The author discusses the evidence and ethics of universal masking for COVID-19, and  
31 makes the following primary points: 1) policy makers must rely on the best available evidence  
32 rather than awaiting the strongest evidence when devising urgent policies that can potentially  
33 save human lives during a pandemic; 2) there is “no shortage of mechanistic evidence and  
34 observational studies that affirmed the benefits of wearing a face mask in the community,” and  
35 such evidence should drive urgent public health policy until further research yields results; and  
36 3) there is “no valid scientific evidence” to support that face mask use in the community may  
37 pose a higher risk of infection due to improper use or false sense of security. (Ex. R66 at 1; Tr.  
38 II at 193.)  
39

40 151. *PLOS One* published an article on January 22, 2021, titled “Comparing the fit of  
41 N95, KN95, surgical, and cloth face masks and assessing the accuracy of fit checking. (Ex. A64  
42 at 1-19; Tr. IV at 218-219.) The seven participants evaluated N95 and KN95 masks by  
43 performing a fit check, and then underwent quantitative fit testing wearing five N95 masks, a  
44 KN95 mask, a surgical mask, and fabric masks. Although the N95 masks offered higher degrees  
45 of protection than the other categories of masks tested, “most N95 masks failed to fit the  
46

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<sup>44</sup> Exhibit R23 is a duplicate of Exhibit R99.

1 participants adequately.” (Ex. R64 at 1.) The authors concluded that “[t]o offer adequate  
2 respiratory protection for the wearer, a face mask must not only be made of high filtration, low  
3 resistance material, but must also fit the wearer. When a face mask has poor fit, the value of high  
4 filtration material decreases such that the wearer achieves similar protection from a fabric face  
5 covering as from a poorly fit KN95 mask.” (*Id.* at 17.)  
6

7 152. The *American Journal of Infection Control* published an article on April 30, 2008,  
8 titled “Surgical mask filter and fit performance.” (Ex. R60 at 1-7; Tr. IV at 216-217.) The study  
9 evaluated the filter performance and facial fit of a sample of surgical masks typically used in  
10 dental offices. All 20 subjects failed the unassisted qualitative fit test on the first exercise, and  
11 18 subjects failed the assisted qualitative fit tests. None of the surgical masks tested exhibited  
12 adequate filter performance and facial fit characteristics to be considered respiratory protection  
13 devices. (Ex. R60 at 1.) The authors concluded that “surgical masks do not offer protection  
14 comparable with that of respiratory protective devices (and are not certified by NIOSH as such).”  
15 (*Id.* at 6.) The authors recommend that the FDA evaluate the use of surgical masks for their  
16 original intended purpose of preventing wound infection, and that healthcare settings seeking  
17 both wound infection prevention as well as respiratory protection consider the use of surgical  
18 N95 respirators. (*Id.*) In Dr. Stern’s opinion, the filter efficiency of a mask is irrelevant without  
19 a good fit. (Tr. IV at 217.)  
20

21 153. *JAMA* published a “Research Letter” on June 4, 2020, titled “Correlation Between  
22 N95 Extended Use and Reuse and Fit Failure in an Emergency Department.” (Ex. R65 at 1-4;  
23 Tr. IV at 219-220.) The authors performed a cross-sectional study of N95 mask fit at an  
24 emergency department where PPE shortages necessitated reuse of the masks. (Ex. R65 at 1.)  
25 Among 68 participants, 38.2% of participants failed the fit test. The authors noted that the study  
26 was designed to detect mask failure based on qualitative fit testing, and that “[f]ailed fit tests  
27 may not necessarily result in increased rates of infection.” (*Id.* at 3.) In Dr. Stern’s opinion, the  
28 N95 mask is the only mask that even has the potential to have an airtight seal, and the fact that a  
29 third of them failed to fit properly in this study supports his position that masks fail at respiratory  
30 viral protection. (Tr. IV at 219-220.)  
31

32 154. The *American Institute for Economic Research (AIER)* published an article by Paul  
33 E. Alexander on February 11, 2021, titled “Masking: A Careful Review of the Evidence.” (Ex.  
34 R98; Tr. II at 197-198.) The author concludes that, “when we look at the science, there is  
35 emerging and troubling evidence of harms from mask use in the absence of any benefits.”<sup>45</sup> (Ex.  
36 R98 at 24.) Dr. Nolt does not consider it a persuasive article because the author is not a medical  
37 expert, the author cites to and reviews some articles that are not medically based, *AIER* is not a  
38 medical or scientific publication, and it is not peer-reviewed. (Tr. II at 198.)  
39

40 155. *Technocracy News* published an online article by Russel Blaylock, MD, on May 11,  
41 2020, titled “Face Masks Pose Serious Risks to the Healthy.” (Ex. R4 at 1-10; Tr. II at 200.) Dr.  
42 Blaylock believes there is “no scientific evidence necessitating the wearing of a face mask for  
43 prevention” of COVID-19, that masks pose serious health risks to individuals (with or without  
44

45 <sup>45</sup> Some potential harms set forth in the article include CO2 intoxication, breathing difficulties, inhalation of toxic  
46 substances from the masks, psychological damage, sudden cardiac arrest (in children), hypoxia, and hypercapnia.  
(See Ex. R98 at 21-22.)

1 comorbidities), that the virus is a “relatively benign infection for the vast majority of the  
2 population,” that most at-risk individuals will survive infection, and that “by letting the virus  
3 spread through the healthier population we will reach a herd immunity level rather quickly that  
4 will end this pandemic quickly and prevent a return next winter.” (Ex. R4 at 4-8.) *Technocracy*  
5 *News* is not a scientific, medical, or clinical publication. The work is not peer-reviewed. (Tr. II  
6 at 201.) Dr. Blaylock is a retired neurosurgeon who now devotes his attention to nutritional  
7 research. (Ex. R4 at 10.) In Dr. Nolt’s opinion, Dr. Blaylock’s lack of an infectious disease  
8 background diminishes the persuasiveness of his article. In her opinion, someone without  
9 expertise in infectious disease likely lacks a breadth of knowledge as to germs, how they grow,  
10 how they are transmitted, and how they would manifest in a patient; what testing is appropriate  
11 to detect if an infection is present; how best to treat an infection; and how best to prevent it. (Tr.  
12 II at 200.)  
13

14 156. *River Cities Reader*, an online monthly magazine, published an article by Denis G.  
15 Rancourt, PhD, on June 11, 2020, titled “Masks Don’t Work: A Review of Science Relevant to  
16 COVID-19 Social Policy.” (Ex. R7 at 1-14; Tr. II at 204.) Dr. Rancourt is a former professor of  
17 physics, and it is unknown whether he has a medical education. (Tr. II at 204.) In Dr. Sutton’s  
18 opinion, the article is “quite biased,” and would not pass peer review. (Tr. I at 156.) The  
19 author’s position is that masks are ineffective and that there are no credible studies that support  
20 masking. (See Ex. R7 at 2.) In Dr. Sutton’s opinion, the author “cherry picks” takeaways from  
21 various studies. (Tr. I at 156.) The article is not peer-reviewed and it does not appear in a  
22 scientific, medical, or clinical publication. In Dr. Nolt’s opinion, the author takes information  
23 from published studies out of context and he also relies on non-scientifically based information.  
24 (Tr. II at 204-205.)  
25

26 157. The publication *Science, Public Health Policy, and The Law*, in association with the  
27 “Institute for Pure and Applied Knowledge (IPAK) Public Health Policy Initiative (PHPI)”  
28 published an article on October 12, 2020, titled “COVID-19 Data Collection, Comorbidity &  
29 Federal Law: A Historical Retrospective.” (Ex. R102 at 1-25; Tr. II at 59-60.) The authors  
30 assert that the CDC has generated inaccurate data regarding death statistics for COVID-19,  
31 thereby grossly overestimating the number of COVID-19 caused deaths, and then advocating for  
32 restrictive mitigation policies based on the inaccurate data. The Abstract states, in part:  
33

34 For a nation tormented by restrictive public health policies mandated for  
35 healthy individuals and small businesses, this is the most important  
36 statistical revelation of this crisis. This revelation significantly impacts  
37 the published fatalities count due to COVID-19. More importantly, it  
38 exposes major problems with the process by which the CDC was able to  
39 generate inaccurate data during a crisis. The CDC has advocated for  
40 social isolation, social distancing, and personal protective equipment use  
41 as primary mitigation strategies in response to the COVID-19 crisis, while  
42 simultaneously refusing to acknowledge the promise of inexpensive  
43 pharmaceutical and natural treatments.  
44

45 (Ex. R102 at 1; Tr. II at 59.) The authors conclude that the CDC may have “willfully failed to  
46 collect, analyze, and publish accurate data used by elected officials to develop public health

1 policy for a nation in crisis.” (Ex. R102 at 21.) In Dr. Farris’ opinion, the article contains  
2 specious arguments and is not scholarly or scientific. (Tr. II at 59-60.)  
3

4 158. *Swiss Policy Research* published an online article in September 2020, titled “WHO  
5 Mask Study Seriously Flawed.” (Ex. R10 at 1-5.) Licensee was unable to identify an author of  
6 the article or offer any information about *Swiss Policy Research*. (See Tr. IV at 153-154.) In Dr.  
7 Nolt’s opinion, the article lacks “any medical or scientific contribution.” (Tr. II at 207.)  
8

9 159. An online news platform, *Townhall.com*, published an article titled, “New Study  
10 Shows Mask Mandates had Zero Effect in Florida or Nationwide, but the Lie Continues.” (Ex.  
11 R8 at 1-5; Tr. IV at 145-148; Tr. II at 205.) The article is not peer-reviewed, it was written by  
12 individual with no known medical or scientific credentials, and it references a study that is only  
13 available on Twitter. (Tr. II at 205-206.) In Dr. Nolt’s opinion, the article has “no benefit to  
14 clinical decision-making.” (*Id.* at 206.)  
15

16 160. An online news source, *LifeSite*, published an article on February 16, 2021, titled  
17 “Masks ‘a possible risk’ for spreading COVID, ‘predisposing’ people to infections: study.” (See  
18 Ex. R101 at 1-2; Tr. II at 62.) As of February 18, 2021, the article “has temporarily been pulled  
19 out of an abundance of caution while *LifeSite* does more research on the peer-review process of  
20 this medical journal, which was only established last fall.” (Ex. R101 at 2; Tr. II at 62.)  
21

22 161. In a February 15, 2021 open letter to leaders at the White House, the CDC, and the  
23 National Institutes of Health (NIH), multiple signatories in the health and science fields  
24 encouraged the federal government to increase production of N95 respirators and higher-quality  
25 surgical masks, and strengthen recommendations for higher level respiratory protection for  
26 healthcare workers and the general public based on science indicating that “inhalation of small  
27 aerosol particles is an important and significant mode of SARS-CoV-2 virus transmission.” (Ex.  
28 R106 at 1-6; see Tr. IV at 60-61.)  
29

30 162. The CDC’s publication, “2007 Guideline for Isolation Precautions: Preventing  
31 Transmission of Infectious Agents in Healthcare Settings,” which was last updated in July 2019,  
32 states, in part:  
33

34 Droplet transmission is, technically, a form of contact transmission, and some  
35 infectious agents transmitted by the droplet route also may be transmitted by  
36 the direct and indirect contact routes. However, in contrast to contact  
37 transmission, respiratory droplets carrying infectious pathogens transmit  
38 infection when they travel directly from the respiratory tract of the infectious  
39 individual to susceptible mucosal surfaces of the recipient, generally over  
40 short distances, necessitating facial protection. \* \* \* \*. Based on these  
41 considerations, it may be prudent to don a mask when within 6 to 10 feet of  
42 the patient or upon entry into the patient’s room, especially when exposure to  
43 emerging or highly virulent pathogens is likely[.]  
44

45 (See Ex. A35 at 1, 18.) With regard to the CDC’s recommendation, above, Dr. Stern believes  
46 there is a relevant distinction between “a high-risk setting like a hospital,” and an outpatient



1 clinic setting. (Tr. IV at 239.) With regard to a high-risk hospital setting, he would without  
2 “question \* \* \* wear a mask in the room.” (*Id.*)  
3

4 163. The CDC has published a slide deck titled “The Science of Masking to Control  
5 COVID-19,” which was valid as of November 16, 2020, and states, in part:  
6

- 7 • COVID-19 infection is spread primarily exposure to respiratory droplets  
8 exhaled by infected people when they breathe, talk, cough, sneeze, or sing.  
9
- 10 • Most of the droplets are less than 10 microns, and are often referred to as  
11 aerosols.  
12
- 13 • An estimated 40 to 45 percent of COVID-19 infected people never  
14 develop symptoms.  
15
- 16 • Among people who do develop symptomatic illness, transmission risk  
17 peaks just before symptom onset and for a few days thereafter.  
18
- 19 • It is estimated that more than 50 percent of all COVID-19 infections are  
20 transmitted by people not exhibiting symptoms.  
21
- 22 • Cloth masks block most large (*i.e.*, greater than 20 to 30 microns)  
23 exhaled respiratory droplets.  
24
- 25 • Multilayer cloth masks “substantially” (*i.e.*, possibly as much as 50 to 70  
26 percent) block respiratory droplets between 1 and 10 microns in size,  
27 which comprise the greatest fraction of exhaled respiratory droplets.  
28
- 29 • The performance of cloth masks in filtering inhaled small droplets is not  
30 as effective as their performance in blocking exhaled small droplets.  
31
- 32 • Cloth masks are comparable to surgical masks when used in tandem for  
33 community control (*i.e.*, when used for both source control and personal  
34 protection).  
35

36 (Ex. A18 at 1-4, 7-8, 11, 18; Tr. I at 150.)  
37

### 38 **Ongoing Circumstances** 39

40 164. As of March 15, 2021, COVID-19 has caused the deaths of more than 2.5 million  
41 people worldwide and more than 530,000 people in the United States. (Tr. I at 122.)  
42  
43  
44

45 ///  
46

1 165. If Licensee is permitted to resume his medical practice, he will not wear a mask  
2 while providing patient care and he will not require his clinic staff to wear a mask.<sup>46</sup> (Tr. I at  
3 74.)  
4

## 5 CONCLUSIONS OF LAW 6

7 1. Licensee's continued practice of medicine constitutes an immediate danger to the  
8 public and a serious danger to the public health or safety. ORS 183.430(2); ORS 677.205(3);  
9 and OAR 137-003-0560(1).  
10

11 2. Circumstances at the time of this final order<sup>47</sup> hearing justify confirmation of the  
12 Board's December 4, 2020 Order of Emergency Suspension of License.  
13

## 14 OPINION<sup>48</sup> 15

### 16 *Legal Framework* 17

18 It is well-settled that "the police power of the states extends to the regulation of certain  
19 trades and callings, particularly those which closely concern the public health." *Dent v. W. Va.*, 129 US 114, 122  
20 (1889). With respect to current pandemic, the Oregon Supreme Court has made clear that the Governor and the  
21 government of Oregon have the authority to enforce emergency regulations and emergency orders to protect the  
22 health and safety of the people of Oregon. *Elkhorn Baptist Church v. Brown*, 366 Or 506 (2020).  
23

24 By law, the responsibility of the Oregon Medical Board is to protect public health and  
25 safety by regulation of the medical profession. As ORS 677.015 provides:  
26

27 Recognizing that to practice medicine is not a natural right of any person but is a  
28 privilege granted by legislative authority, it is necessary in the interests of the health,  
29 safety and welfare of the people of this state to provide for the granting of that privilege  
30 and the regulation of its use, to the end that the public is protected from the practice of  
31 medicine by unauthorized or unqualified persons and from unprofessional conduct by  
32 persons licensed to practice under this chapter.  
33

34 <sup>46</sup> At hearing, when addressing whether he would currently change anything about his medical practice with regard  
35 to masking, Licensee testified, in part:

36 If I have to sacrifice my medical license versus sacrificing my personal integrity  
37 as a physician before God, I choose to sacrifice my medical license with no  
38 hesitation. If I have to pay the price of the emotional trauma to my wife and to  
39 myself and to my patients just in order to maintain my personal integrity because  
40 I dared to defy the unlawful mandate of what I consider to be a rogue governor,  
41 Kate Brown, an authoritarian totalitarian ruler of Oregon who is going to tell me  
42 how to practice medicine, I am going to pay whatever price it takes. I will \* \* \*  
43 never compromise my integrity before God. I will never compromise my  
44 responsibility to my patients[.]  
45

46 (Tr. V at 81-82.)

<sup>47</sup> We modify this phrase to reflect the now-relevant date.

<sup>48</sup> We modify the opinion to include additional, relevant, legal framework.

1 As the Oregon Supreme Court stated in *In re Buck's License*, 192 Or 66 (1951), "while  
2 the right of the Respondent to practice his profession is a valuable one and is in the nature of a  
3 property right of which he cannot be arbitrarily deprived, it is, nevertheless, a privilege  
4 subordinate to the duty of the state to enact reasonable laws to protect the public health and  
5 safety." *Id.* at 76-77. That is what the Board has done here: protect the public health and safety.  
6

7 As the Supreme Court has noted, "a community has the right to protect itself against an  
8 epidemic of disease which threatens the safety of its members." *Jacobson v. Massachusetts*, 197  
9 US 11, 27 (1905). Such an emergency requires that states have the power to enact health laws  
10 and policies "of every description." *Id.* at 25. See, e.g., *Compagnie Francaise de Navigation a*  
11 *Vapeur v. Bd. of Health of State of La.*, 186 US 380 (1902) (upholding quarantine law against  
12 constitutional challenges); *Rasmussen v. Idaho*, 181 US 198 (1901) (permitting a ban on certain  
13 animal imports if evidence of disease was found); see also *Elkhorn Baptist Church v. Brown*,  
14 366 Or 506 (2020) (upholding Governor's and government's right to enforce emergency  
15 regulations and orders to protect public health and safety); *Benson v. Walker*, 274 F 622 (4<sup>th</sup> Cir.  
16 1921) (upholding board of health resolution that prevented carnivals and circuses from entering a  
17 certain county in response to the 1918-1919 influenza epidemic); *Hickox v. Christie*, 205 F Supp  
18 3d 579 (D. N.J. 2016) (upholding the eighty-hour quarantine of a nurse returning from treating  
19 Ebola patients in Sierra Leone).  
20

21 Although Licensee questions the wisdom of the Board (and OHA, and OSHA) on the use  
22 of masks, it is not the Board's burden to prove masks work. Licensee's argument that he is  
23 correct on the science of masks is analogous to a lawyer in front of a disbarment procedure  
24 arguing that the Oregon State Bar is wrong to prohibit communication with a represented party.  
25 Disagreeing with the substance of the regulation is not a basis for Licensee to prevail. That said,  
26 it is the Board that is following the credible, evidence-based, and overwhelming majority of  
27 accepted science. Wearing and requiring patients and staff to wear masks protects public health  
28 in a global pandemic and saves lives.  
29

30 The Board is statutorily vested with the authority to regulate the practice of medicine in  
31 Oregon. ORS 677.265 states, in part:  
32

33 In addition to any other powers granted by this chapter, the [Board] may:  
34

35 (1) Adopt necessary and proper rules for administration of this chapter  
36 including but not limited to:  
37

38 \* \* \* \* \*

39  
40 (c) Enforcing the provisions of this chapter and exercising general  
41 supervision over the practice of medicine and podiatry within this state[.]  
42

43 (2) Issue, deny, suspend and revoke licenses and limited licenses, assess  
44 costs of proceedings and fines and place licensees on probation as  
45 provided in this chapter.  
46

///

1 \* \* \* \* \*

2  
3 (10) Administer oaths, issue notices and subpoenas \* \* \*, hold hearings  
4 and perform such other acts as are reasonably necessary to carry out its  
5 duties under this chapter.  
6

7 On December 4, 2020, the Board issued an Order of Emergency Suspension of License,  
8 immediately suspending Licensee's license to practice medicine in Oregon until further order of  
9 the Board, after concluding that Licensee's continued practice constitutes an immediate danger  
10 to the public and presents a serious danger to the public health and safety.  
11

12 The Board's statutory authority for issuing an emergency suspension order is set forth in  
13 ORS 183.430(2) (generally) and ORS 677.205(3) (Board-specifically).  
14

15 ORS 183.430(2) states, in part:  
16

17 In any case where the agency finds a serious danger to the public health or  
18 safety and sets forth specific reasons for such findings, the agency may  
19 suspend or refuse to renew a license<sup>49</sup> without hearing, but if the licensee  
20 demands a hearing within 90 days \* \* \* then a hearing must be granted to  
21 the licensee as soon as practicable after such demand, and the agency shall  
22 issue an order pursuant to such hearing as required by this chapter  
23 confirming, altering or revoking its earlier order[.]  
24

25 ORS 677.205(3) states, in relevant part:  
26

27 [T]he [B]oard may temporarily suspend a license without a hearing,  
28 simultaneously with the commencement of proceedings under ORS  
29 677.200<sup>50</sup> if the [B]oard finds that evidence in its possession indicates that  
30 a continuation in practice of the licensee constitutes an immediate danger  
31 to the public.  
32

33 <sup>49</sup> The term "license" is broadly defined to include "any agency permit, certificate, approval, registration  
34 or similar form of permission required by law to pursue any commercial activity, trade, occupation or  
35 profession." ORS 183.310(5).  
36

37 <sup>50</sup> ORS 677.200 is titled "Disciplinary procedure" and states, in part:  
38

39 Except as provided in ORS 677.202 or 677.205(1)(a), any proceeding for  
40 disciplinary action of a licensee licensed under this chapter shall be substantially  
41 in accord with the following procedure:  
42

43 (1) A written complaint of some person, not excluding members or employees of  
44 the Oregon Medical Board, shall be verified and filed with the board.

45 (2) A hearing shall be given to the accused in accordance with ORS chapter 183  
46 as a contested case.

OAR 137-003-0560 provides additional criteria relevant to an emergency license suspension and states, in part:<sup>51</sup>

(1) If the agency finds there is a serious danger to the public health or safety, it may, by order, immediately suspend \* \* \* a license. For purposes of this rule, such an order is referred to as an emergency suspension order. An emergency suspension order must be in writing. It may be issued without prior notice to the licensee and without a hearing prior to the emergency suspension order.

\* \* \* \* \*

(6) At the hearing regarding the emergency suspension order, the administrative law judge shall consider the facts and circumstances including, but not limited to:

(a) Whether the acts or omissions of the licensee pose a serious danger to the public health or safety; and

(b) Whether circumstances at the time of the hearing justify confirmation, alteration or revocation of the order[.]

Here, the Board must establish, by a preponderance of the evidence, that it was entitled to suspend Licensee's license to practice medicine without prior notice and opportunity for hearing, and that circumstances at the time of the hearing and issuance of final order<sup>52</sup> justify continued suspension. *See* ORS 183.450(2) ("The burden of presenting evidence to support a fact or position in a contested case rests on the proponent of the fact or position"); *Harris v. SAIF*, 292 Or 683, 690 (1982) (general rule regarding allocation of burden of proof is that the burden is on the proponent of the fact or position); *Dixon v. Board of Nursing*, 291 Or App 207, 213 (2018) (in administrative proceedings, the preponderance standard generally applies). Proof by a preponderance of the evidence means that the fact finder is persuaded that the facts asserted are more likely than not true. *Riley Hill General Contractor v. Tandy Corp.*, 303 Or 390, 402 (1987).

*OHA's Guidance and Executive Order No. 20-27*

Licensee makes several arguments pertaining to the OHA's July 22, 2020 guidance document titled, "Statewide Mask, Face Covering, Face Shield Guidance for Health Care

<sup>51</sup> Pursuant to ORS 183.341(1), the Oregon Attorney General promulgated the Model Rules of Procedure for Contested Cases (Model Rules). The Model Rules applicable to contested case proceedings before the OAH (such as this current proceeding) are found at OAR 137-003-0501 through 137-003-0700. *See* OAR 137-003-0000(2); OAR 137-003-0501(1). Pursuant to ORS 183.341(2) and 183.630(1), the Board adopted the Model Rules, and such rules of procedure are therefore controlling in this matter. *See* OAR 847-001-0005.

<sup>52</sup> We modify this phrase to include the now-relevant period.

1 Offices” (July 22, 2020 OHA Guidance) and the Governor’s Executive Order No. 20-27. For the  
2 reasons that follow, such arguments are not persuasive.  
3

4 First, Licensee argues that the July 22, 2020 OHA Guidance regarding Covid-19  
5 protocols in healthcare settings lacks the force of law and was therefore not binding upon him  
6 and his practice of medicine. He contends that the term “guidance” denotes a suggestion and not  
7 a mandate with which he was required to comply. *See* Licensee’s Closing Argument at 1-2; *see*  
8 *also* Transcript I at 39 (Licensee’s Opening Statement) (asserting that “there was never any rule  
9 imposed upon [Licensee] directing him or other medical professionals that they are required to  
10 wear a mask or impose masks upon their patients”).  
11

12 Second, Licensee argues that the Board is seeking to enforce the July 22, 2020 OHA  
13 Guidance against him, contrary to the enforcement provisions set out in the guidance document  
14 itself (stating that it is enforceable as specified in Executive Order No. 20-27), Executive Order  
15 No. 20-27 (stating that executive orders and OHA guidance are considered public health laws  
16 and may be enforced under ORS 431A.010 and ORS 401.990), ORS 431A.010 (authorizing the  
17 OHA to issue administrative compliance orders, seek civil penalties, maintain civil actions, and  
18 refer matters for criminal prosecution), and ORS 401.990 (designating certain knowing  
19 violations of ORS Chapter 401 as class C misdemeanors). Licensee asserts that neither the July  
20 22, 2020 OHA Guidance nor Executive Order 20-27 constitutes a “public health law” under ORS  
21 Chapter 431A, and even if they could be construed as such, suspension or revocation of a  
22 professional license is not a permitted penalty under ORS 431A.010 or ORS 401.990. *See*  
23 Licensee’s Closing Argument at 2-4.  
24

25 Licensee’s arguments are based on the mistaken premise that the Board has sought to  
26 discipline him under the provisions of Executive Order No. 20-27 for failing to comply with the  
27 provisions of that executive order or the OHA guidance issued therefrom. That is not correct.  
28 As stated in the Emergency Suspension Order, the Board suspended Licensee’s medical license,  
29 *pursuant to ORS 677.205(3) and ORS 183.430(2)*, after determining that his continued practice  
30 of medicine constituted an immediate danger to the public and a serious danger to the public  
31 health or safety. *See* Pleading P1 at 1 (*italicized emphasis added*). The Board explained in the  
32 Emergency Suspension Order that when making determinations regarding public health and  
33 safety, the Board “relies upon sources that are well recognized in the medical community and are  
34 relied upon by physicians in their delivery of care to patients.” *Id.* at 1-2. In this matter, the  
35 Board relied upon “basic principles of transmission of respiratory viruses and respiratory  
36 pathology,” as well as OHA guidelines pertaining to COVID-19 and other sources to inform its  
37 determination. *See id.* at 2.  
38

### 39 *Notice of Masking Requirements and Potential Disciplinary Actions*<sup>53</sup> 40

41 Licensee argues that the Board failed to provide him with sufficient notice of his  
42 obligation to follow the OHA’s guidance on masking for healthcare workers and patients in  
43 healthcare settings. He also asserts that the Board failed to sufficiently apprise him of “the  
44 punishment that may befall him if he failed to comply” with the masking requirements, urging  
45

46 <sup>53</sup> The Board modifies this portion of the analysis to accurately reflect the standards for orders of emergency  
suspension, which apply here, rather than for pre-deprivation notice, which do not.

1 that it is “inherently unjust” to penalize a person “without notice of \* \* \* what constitutes an  
2 offense and what the penalty will be.” See Licensee’s Closing Argument at 4-5.  
3

4 It is a well-established principle that due process requires notice and opportunity to be  
5 heard. See *California ex rel. Lockyer v. FERC*, 329 F3d 700, 708 n.6 (9<sup>th</sup> Cir. 2003). But  
6 “[p]recisely what procedures the Due Process Clause requires in any given case is a function of  
7 context.” *Brewster v. Board of Educ. Of Lynwood Unified Sch. Dist.*, 149 F.3d 971, 983 (9<sup>th</sup> Cir.  
8 1998). “[D]ue process is flexible and calls for such procedural protections as the particular  
9 situation demands.” *Morrissey v. Brewer*, 408 US 471, 481, 92 SCt 2593, 2600 (1972). The  
10 U.S. Supreme Court “has recognized, on many occasions, that where a State must act quickly, or  
11 where it would be impractical to provide pre-deprivation process, post-deprivation process  
12 satisfies the requirements of the Due Process Clause.” *Gilbert v. Homar*, 520 US 924, 930-31,  
13 117 S. Ct. 1807, 1812 (1997) (listing cases).  
14

15 The Board is subject to APA and Model Rules. When there is a serious danger to the  
16 public and the State must act quickly, as was the case here, it is authorized to issue an emergency  
17 order of suspension, which provides the appropriate post-deprivation process.<sup>54</sup> ORS 183.430,  
18 OAR 137-003-0560(2)(b). Specifically, the notice required by OAR 137-003-0560(2), which  
19 must be provided within the Order of Emergency of Suspension, must include:

- 20 (A) The effective date of the emergency suspension order;  
21  
22 (B) Findings of the specific acts or omissions of the licensee that violate  
23 applicable laws and rules and are the grounds for revocation, suspension or  
24 refusal to renew the license in the underlying proceeding affecting the license;  
25  
26 (C) The reasons the specified acts or omissions seriously endanger the public's  
27 health or safety;  
28  
29 (D) A reference to the sections of the statutes and rules involved;  
30  
31 (E) That the licensee has the right to demand a hearing to be held as soon as  
32 practicable to contest the emergency suspension order; and  
33  
34 (F) That if the demand for hearing is not received by the agency within 90  
35 calendar days of the date of notice of the emergency suspension order the licensee  
36 shall have waived its right to a hearing regarding the emergency suspension order.

37 The Board included all of these items in its Order of Emergency Suspension. See P.1.  
38 Prior to issuing its Order of Emergency Suspension of License, the Board was under no  
39 obligation — under the APA, Model Rules, or general principles of due process — to personally  
40 notify Licensee of any or all laws, rules, guidelines, ethical standards, practice standards, or  
41 disciplinary sanctions that might govern licensee’s exercise of his license to practice medicine in  
42 Oregon.

43 Moreover, as a practical matter, it is simply not credible that Licensee was unaware *as*  
44 *late as August 2020*, when Board staff first contacted him regarding an investigation into the  
45

46 <sup>54</sup> See also Ex. A20 (*LaTulippe v. Harder et al.*, Case No. 3:21-cv-00090-HZ, Federal District Court, District of Oregon (February 4, 2021)).

1 current matter, that there were masking requirements (or “guidelines,” or “mandates”) in place  
2 for healthcare providers in healthcare settings. Even if Licensee was not in receipt of, or had not  
3 actually read, the Governor’s executive orders or the OHA’s guidance documents pertaining to  
4 masking in healthcare facilities by August 2020, it is disingenuous for him to assert in this  
5 proceeding that he was unaware up until that time of any obligation to comply with masking  
6 requirements in his clinic. Nonetheless, *at the very least*, Licensee was placed on notice of such  
7 requirements upon receiving Board Investigator Carruth’s August 13, 2020 letter, which stated  
8 that the Board was investigating complaints against him that included “advising patients and the  
9 public that masks required under the current guidelines do not work and should not be worn.”  
10 See Exhibit A5 at 1. Indeed, in Licensee’s September 3, 2020 letter to the Board, he admitted to  
11 advising patients and the public that masks “required under the current COVID-19 guidelines”  
12 are ineffective and should not be worn. See *id.* at 2. Licensee’s letter also specifically addressed  
13 Board allegations of “not following guidelines” and “noncompliance with a government order,”  
14 stating, in part:

15  
16 What exactly is the purpose of guidelines? If a face mask is completely  
17 ineffective against disease transmission, but a state governor seeks to  
18 enforce such guidelines, should we just oblige her? What motive has Kate  
19 Brown in declaring such a mandate? Does she have authority to do so?

20  
21 \* \* \* \* \*

22  
23 [I]f a guideline is unlawful, has no medically-based validity, and is  
24 detrimental to personal health, I cannot accept such a guideline, mandate,  
25 order, regulation – or whatever other name you choose to assign it[.]

26  
27 *Id.* at 5. Subsequently, in a November 9, 2020 letter to Licensee, Dr. Farris notified Licensee  
28 that he might be in “direct and active violation” of the Governor’s executive orders, OHA  
29 guidance, and/or OHA administrative rules that “require all people to wear properly fitted  
30 facemasks when indoors in any care setting.” Exhibit A4 at 1. Dr. Farris further stated that the  
31 Board expected Licensee to “immediately comply not only with the legal mandate, but with  
32 practices and professional conduct appropriate to the standards of medical care expected” for a  
33 licensed physician in Oregon. *Id.* Dr. Farris closed the letter by stating that Licensee could be  
34 “subject to administrative sanctions.” See *id.*

35  
36 Licensee’s purported failure to understand, prior to receiving the Board’s Order of  
37 Emergency Suspension, that the range of administrative sanctions available to the Board includes  
38 significant actions such as license suspension and revocation,<sup>55</sup> as specifically set forth in ORS  
39 677.190, is immaterial to the Board’s exercise of its authority in the current matter. ORS  
40 677.205(3) and ORS 183.430(2) grant the Board the authority to immediately suspend a  
41 Licensee’s license upon its determination that the Licensee’s conduct endangers public health  
42 and safety. There is no legal requirement for the Board to provide advance notice to a Licensee  
43 that their conduct endangers public health and safety.

44  
45  
46 <sup>55</sup> See Licensee’s Closing Argument at 5 (stating that Licensee “did not understand ‘administrative sanctions’ to include license suspension”).



1 Finally, based upon Licensee's interactions with the Board since August 2020 and his  
2 hearing testimony, Licensee was aware of the Governor's Executive Order and the guidance and  
3 recommendations for mask wearing in health care settings, as well as the Board's concerns, but  
4 chose to disregard the order, recommendations, and concerns. As late as the date of the hearing  
5 in this contested case proceeding, Licensee insisted that he would rather lose his license than  
6 comply with the Executive Order or the OHA Guidance on masking requirements in the health  
7 care setting. The record establishes that Licensee was aware of the potential consequences of his  
8 refusal to change his masking practices and, even after becoming fully cognizant of those  
9 consequences, has maintained his refusal to change his practices regardless of the outcome of  
10 this proceeding.

### 11 12 *The Role of Masking in Preventing the Transmission of SARS-CoV-2*

13

14 In March 2020, the OHA issued "Clinical Care, and Healthcare Prevention and Control  
15 Guidance for COVID-19," recommending masking for both patients and providers in all  
16 healthcare settings. The OHA issued a revision to that guidance in May 2020, requiring all  
17 patients and visitors (unless unable to tolerate masking) to wear a face mask or face covering  
18 while in a healthcare setting, and requiring all healthcare providers and healthcare personnel to  
19 wear a face mask at all times in such a setting (unless alone in a private office). In July 2020, the  
20 OHA issued another revision to the guidance to clarify the masking requirements for healthcare  
21 offices that were already in place. See Transcript I at 115-118, 182-184, 186, 190-191; Exhibits  
22 A9 and A23. The record persuasively establishes that by at least July 2020, consistent with  
23 recommendations from the WHO,<sup>56</sup> the CDC,<sup>57</sup> and the OHA, the standard of care for healthcare  
24 professionals in Oregon was for healthcare providers to mask at all times in all healthcare  
25 settings (unless alone in a private office). See Transcript I at 118-119 (Dr. Sutton's testimony);  
26 Transcript II at 190-191 (Dr. Nolt's testimony).

27  
28 Licensee contends that there is no benefit to wearing cloth masks, surgical masks, or N95  
29 masks to prevent or reduce the transmission of COVID-19. He contends that SARS-CoV-2 virus  
30 is spread predominantly through aerosols, and that masks are incapable of blocking aerosols. He  
31 asserts that universal masking is contributing to an increased spread of COVID-19 and that mask  
32 wearing poses risk of harm to wearers, particularly if they are elderly or have certain  
33 comorbidities. He contends that asymptomatic spread has not been sufficiently demonstrated in  
34 the medical literature and is not a significant factor in the transmission of COVID-19. Finally,  
35 he asserts that there are "at least 17 well-designed randomized controlled trials that eliminated  
36 any question about masks being effective." See Transcript I at 82, 56-58, 86, 101; Transcript III  
37 at 26, 28-29; Transcript IV at 88; Transcript V at 30, 32.

38  
39 Licensee's positions on masking differ starkly from the positions of the CDC and the  
40 OHA, a significant number of peer-reviewed studies and medical journal articles (including  
41

---

42  
43 <sup>56</sup> See Exhibit R81 at 1-16 (WHO's June 5, 2020 interim guidance document titled "Advice on the use of masks in  
44 the context of COVID-19").

45  
46 <sup>57</sup> See Exhibit A10 at 1-5 (CDC's June 2020 guidance for managing operations of healthcare facilities  
recommending that healthcare personnel in healthcare facilities wear face masks and that patients and  
visitors to healthcare facilities wear face coverings or face masks).

1 several offered by Licensee to prove the inverse), and the consensus of the medical community,  
2 which was represented at hearing through the expert testimony of Drs. Sutton, Nolt, and Farris.  
3

4 The documentary evidence offered by the Board to support the safety of masking and its  
5 efficacy in providing protection from the spread of viral respiratory pathogens, including SARS-  
6 CoV-2, consists primarily of peer-reviewed articles and studies published in respected medical  
7 and scientific journals and other medical publications (e.g., Exhibits A11, A12, A15, A17, A21,  
8 and A22) and guidance documents from the CDC and the OHA (e.g., Exhibits A9, A10, A18,  
9 and A23).  
10

11 To support his positions on masking, Licensee offered testimony at hearing from Dr.  
12 Stern, a pulmonologist licensed in North Carolina with no expertise in public health, infectious  
13 disease, or epidemiology, and Ms. Kelly, an individual with 18 years of experience as an  
14 industrial hygienist but no formal medical training or medical licensure.  
15

16 The documentary evidence offered by Licensee to show that mask wearing is unsafe and  
17 inefficacious in preventing the spread of viral respiratory pathogens, including SARS-CoV-2,  
18 ranges from randomized controlled trials and other studies published in respected peer-reviewed  
19 journals (e.g., Exhibits R6, R17, R23, R39, R65) to online articles written by non-medical and  
20 non-scientific experts in non-medical and non-scientific publications (e.g., Exhibits R4, R5, R7,  
21 R8, R10, R16, R28, R71, R98, R100). Some of Licensee's documentary evidence has unknown  
22 significance to the relevant issues (e.g., Exhibits R29, R73, R74), some articles were  
23 anonymously written or failed to identify an author (e.g., Exhibits R5, R10, R11), one article  
24 involved a study only available on Twitter (Exhibit R8), one article was withdrawn (Exhibit  
25 101), and multiple articles were marked by strident advocacy and obvious bias (e.g., Exhibits R7,  
26 R8, R11, R98, R100). Articles that are not authored by medical or scientific experts, Twitter  
27 articles, withdrawn articles, and articles with significant bias provide no legitimate support for  
28 Licensee's position. Additionally, the limited number of peer-reviewed journals that cast some  
29 doubt on the efficacy of masks fails to outweigh the predominance of the medical literature that  
30 supports the use of masks during this pandemic.  
31

32 Lacking any formal medical education, Ms. Kelly's opinions and assessments of the  
33 medical studies and articles in the field of epidemiology, especially virus transmission, are not  
34 persuasive. Although an expert about the available types of PPE, her goal as an industrial  
35 hygienist is to make recommendations to an employer of the safest and most effective ways to  
36 protect employees. Thus, she supports the use of PAPRs and CAPRs in close contact settings  
37 and N95 masks in other settings involving viral contamination. However, she has no expertise in  
38 making recommendations for the safety of the public masses, who cannot be expected to have  
39 the funds to purchase the expensive respirators or even the N95 masks.  
40

41 Even with her limited area of expertise, Ms. Kelly's expert opinion on the efficacies of  
42 masks do not support Licensee's position. Licensee is a doctor in a healthcare setting having  
43 close contact with patients, including patients with symptoms of COVID-19. In such a setting,  
44 Ms. Kelly's opinion is that Licensee should be wearing a PAPR or a CAPR, something Licensee  
45 and his staff refuse to do. Licensee and his staff are even refusing to wear N95 or surgical  
46 masks, items commonly available in his field. Pursuant to Ms. Kelly's opinions, Licensee's

1 conduct in having close contact with COVID-19 infected patients during this pandemic without  
2 using a respirator endangers himself and his patients.  
3

4 As to cloth and surgical masks, Ms. Kelly's primary concerns are their reduced efficacy  
5 (in comparison with respirators) and the public's lack of knowledge on the proper care and use of  
6 such masks. Licensee is in the position where he could provide instruction and guidance to his  
7 patients in the proper care and use of cloth and surgical masks, something he refuses to do. Ms.  
8 Kelly also supports letting patients make the choice to wear masks in consideration of their  
9 potential disabilities and intolerances. However, Licensee is not letting patients make that  
10 choice. Instead, he is actively dissuading his patients from wearing masks by advising them of  
11 his beliefs that masks are harmful and lack efficacy. He is also passively dissuading them by his  
12 and his staff's failure to wear masks in the clinic. A physician's refusal to wear a mask is an  
13 example to their patients. Thus, Licensee's failure to wear a mask when providing care to his  
14 patients further encourages them to not use masks.  
15

16 Dr. Stern holds board certifications in Sleep Medicine, Pulmonary Medicine, and Critical  
17 Care Medicine and he has a Master's Degree in Clinical Research. In Dr. Stern's opinion, the  
18 data overwhelmingly supports a conclusion that masks do not prevent the spread of respiratory  
19 droplets and that cloth masks can actually do more harm than good by increasing the number of  
20 respirable particles. *See* Transcript IV at 179, 184, 222, 241. At hearing, when opining on the  
21 efficacy of masks to block the transmission of respiratory particles, Dr. Stern was critical of any  
22 device that was not "effective," which he defined as having 99.999996 percent effectiveness in  
23 blocking viral pathogens. *See id.* at 190, 241-242. He did, however, concede that a surgical  
24 mask could be expected to capture approximately 50 percent of the respiratory droplets coming  
25 from a mask worn by a COVID-19 infected source. And, while he considers N95 masks capable  
26 of blocking even more respiratory particles than surgical masks, he nonetheless believes that due  
27 to poor fit, even N95 masks are ineffective in preventing the spread of respiratory viruses such as  
28 SARS-CoV-2. *Id.* at 242-243, 184, 189. Ultimately, Dr. Stern's opinion is akin to Ms. Kelly's  
29 opinion: transmission is best controlled by PAPRs and CPARs with only limited control from  
30 N95 masks and surgical masks. However, as noted above, Licensee refuses to use *any* masking  
31 devices; does not require his staff to wear *any* masking devices; and advises his patients against  
32 using *any* masking devices.  
33

34 As the OHA's Medical Director of Respiratory Viral Pathogens and a Senior Health  
35 Advisor for the OHA on COVID-19 matters, Dr. Sutton acts as a subject matter expert on testing  
36 strategy and policy and conducts daily reviews on the latest evidence and literature pertaining to  
37 the COVID-19 pandemic. In her opinion, the most important measure to mitigate against the  
38 risk of COVID-19 transmission in a healthcare clinic setting is masking. Transcript I at 123-124.  
39 She opines that masks reduce the risk of transmission of virus particles "by a significant  
40 proportion," particularly when both the infected person and the person who may potentially  
41 become infected are masked. *Id.* at 144. In her opinion, the primary role that masks play is with  
42 regard to source control and any mask is better than no mask because even a poorly fitting cloth  
43 mask "will block large droplets quite well." *Id.* at 143, 120-121, 138-139.  
44

45 Dr. Nolt is Director of Pediatric Oncologic and Transplant Infectious Diseases at OHSU-  
46 Doernbecher, as well as the Pediatric Medical Director for Infection Prevention and Control at

1 OHSU-Doernbecher. She is an expert in infectious diseases and serves as the Co-Chair of  
2 OHSU's Infection Control Committee. In her opinion, a COVID-19 infected person can be  
3 contagious even if they are showing no signs or symptoms of infection. Transcript II at 182-184.  
4 Although there are no randomized controlled trials showing that masks protect against  
5 transmission of COVID-19, Dr. Nolt believes there is "an accumulation of very good evidence  
6 showing that masks do decrease COVID-19 transmission." *Id.* at 184-185, 226. In her opinion,  
7 transmission of COVID-19 is based on dose, duration, and distance, with dose capable of being  
8 controlled by masking. *Id.* at 186-187. In her opinion, masking reduces the risk of transmission  
9 of COVID-19, and it is the standard of care for healthcare workers to wear masks in clinical  
10 settings, including direct patient care, during the COVID-19 pandemic.  
11

12 Licensee contends that there is "ample evidence" that mask wearing is contraindicated for  
13 curtailing the spread of COVID-19. Licensee's Closing Argument at 6. To support this  
14 contention, Licensee relies on his own anecdotal accounts of patient harm from mask wearing,<sup>58</sup>  
15 Ms. Kelly's hearing testimony regarding the role and importance of federal OSHA requirements  
16 pertaining to PPE,<sup>59</sup> and documentary evidence such as R4 (a non-peer reviewed article from a  
17 non-scientific, non-medical, and non-clinical source), R29 (a study involving CO2 and gene  
18 expression in bronchial epithelial cells with no clear significance to masking), R50 (educational  
19 website addressing skin issues from mask wearing), R52 (article discussing that face masks may  
20 lead to ocular dryness and irritation), R73 (a study regarding respiratory pressure in adults with  
21 no mention of or clear significance to masking), R73 (a non-published meeting abstract with no  
22 clear significance to masking), and R98 (a non-peer reviewed article from a non-medical, non-  
23 scientific source).  
24

25 As an anesthesiologist, Dr. Farris has expertise in monitoring CO2 levels and in the  
26 concepts of CO2 retention and dead space inhalation. In his opinion, symptoms of CO2 toxicity  
27 would only be expected to occur if a person's CO2 level reached as high as 90 mm/Hg, which is  
28 the equivalent of holding one's breath for an hour. He opines that symptoms of CO2 toxicity  
29 would not occur under conditions created by mere mask-wearing, and would only occur at a  
30 level of CO2 "not achievable short of an unconscious person or a person basically being  
31 suffocated." Transcript II at 53-54. In his opinion, although some vital sign parameters have  
32 been shown to change in trivial directions from mask wearing, the body quickly compensates,  
33 there is no significant increase in CO2 levels or decrease in O2 levels, and masks do not cause  
34 physiologic harm to wearers. He believes that side effects caused from mask-wearing such as  
35 skin breakdown or impetigo, though minor, may warrant exemption from masking mandates. *Id.*  
36 at 49-51.  
37

38 Dr. Nolt acknowledges that masking could cause minor, yet treatable, issues such as  
39 contact dermatitis, acne, and pressure headache. However, in her opinion, numerous studies  
40 show that there is no risk of increased CO2 toxicity or decreased O2 from mask wearing.  
41 Transcript II at 199-200. In Dr. Sutton's opinion, there is "no evidence that masks are not safe  
42 when used appropriately." Transcript I at 144-145. The persuasive medical literature supports  
43 the opinions of Drs. Farris, Nolt and Sutton that mask wearing does not cause CO2 toxicity or  
44 decreased O2 levels, contrary to Licensee's assertions.  
45

46 <sup>58</sup> See Transcript I at 58, 61, 89-92; Tr. IV at 84; Tr. V at 19, 33.

<sup>59</sup> See Transcript IV at 14-18, 23.

1 Based on the various expert opinions and a review of relevant literature in the record, the  
2 preponderance of evidence establishes that COVID-19 is a highly communicable and deadly  
3 disease, that between 40 and 60 percent of people infected with COVID-19 may be  
4 asymptomatic but infectious, that patients become infectious prior to symptom onset, that  
5 masking reduces the risk of transmission of COVID-19 (particularly as source control), and that  
6 masking does not result in significant harm to mask wearers and any actual harm is highly  
7 treatable and quickly resolved by mask removal.  
8

9 *Risk of Harm to Patients, Visitors, and Staff through Exposure to SARS-CoV-2 at Clinic*  
10

11 Except when performing surgical procedures, Licensee did not wear a mask at the clinic  
12 when treating patients — including those with known or suspected COVID-19 infection —  
13 between March 2020 and December 2020. During that time period, Licensee did not require his  
14 staff, Mrs. LaTulippe and Ms. Miles, to wear masks at the clinic, and Licensee did not require  
15 patients or clinic visitors to wear masks unless they were acutely ill or otherwise had signs  
16 suggestive of respiratory illness. He estimates that at least 95 percent of his patients chose not to  
17 wear a mask while at the clinic. *See* Transcript I at 50-52, 54, 60-61; Transcript IV at 90;  
18 Transcript V at 19-20, 36-41.  
19

20 Between late November 2020 and early December 2020, Licensee treated approximately  
21 125 patients with known or presumed COVID-19 in the clinic. He did not wear a mask when  
22 treating those patients, and he did not recommended to those patients that they wear masks  
23 outside of the clinic to contain the spread of their illness. *See* Transcript I at 70; Transcript III at  
24 53; Transcript V at 36-38, 99, 106-109, 111.  
25

26 On more than one occasion, when treating a patient with known or presumed COVID-19  
27 (particularly if the patient was exhibiting profuse symptoms of the illness such as coughing),  
28 Licensee believed it was likely he would contract the virus from the patient. Despite having that  
29 belief, Licensee did not wear a mask during any of those patient encounters, including when he  
30 was in close physical contact with such patients, or during subsequent patient encounters. *See*  
31 Transcript V at 37-41, 112-113, 119-120. At hearing, Licensee conceded that there was a “very  
32 good chance” that he has been infected with SARS-CoV-2, from his exposures to “some very  
33 sick patients” at the clinic. *See id.* at 143, 36, 41, 121, 135. Despite that concession, Licensee  
34 has never been tested for COVID-19. *See id.*  
35

36 The record persuasively establishes that despite his regular contact with infectious  
37 patients and being aware of the likelihood that he had been infected with SARS-CoV-2 during  
38 the course of treating patients in 2020, Licensee did not undergo any periodic testing for the  
39 virus, he continued to treat patients without wearing a mask, he did not require clinic staff to  
40 wear a mask, and he and his staff continued to interact with patients and clinic visitors without  
41 requiring that those individuals take the basis precautionary measure of wearing a mask.  
42 Licensee’s conduct, more likely than not, exposed his patients to a serious risk of harm of  
43 contracting COVID-19.  
44

45 ///  
46

1                   *Risk of Harm to Patients and the Public by Actively Discouraging Mask Use*

2  
3           Licensee contends that he did not actively discourage his patients from wearing masks.  
4   *See* Transcript V at 63-64. However, that contention is contradicted by the preponderance of  
5   evidence in the record.  
6

7           From March to December 2020, Licensee engaged in what he deemed an “informed  
8   consent” process with his patients “to establish whether or not they should be wearing a mask,”  
9   based on his opinions of the medical evidence pertaining to mask-wearing. *See* Transcript I at  
10   54-58, 64; Transcript IV at 104; Transcript V at 21-22, 32. The record demonstrates, more likely  
11   than not, that Licensee discussed the alleged futility and dangers associated with mask wearing  
12   with patients, even when the patients did not ask about mask wearing or complain of adverse  
13   symptoms related to mask wearing. *See, e.g.,* Transcript I at 54-58; Transcript IV at 104;  
14   Transcript V at 21-22. The record also establishes that Licensee routinely directed patients to  
15   watch a YouTube video titled, “Tammy K. Herrera Clark on Face Mask Effectiveness” and he  
16   made available to patients a document advertising Ms. Clark’s YouTube video. *See* Transcript I  
17   at 62-64; Tr. V at 23-24, 27-29; Exhibits A5 at 3, 9 and A6 at 1. Between March and December  
18   2020, Licensee informed a patient who was experiencing elevated blood pressure that wearing a  
19   mask might be contributing to her condition and that she was at greater risk from CO2 toxicity  
20   from mask wearing than she was from getting COVID-19. *See* Transcript V at 168, 170-173;  
21   Transcript VI at 20-21.  
22

23           I conclude that by not wearing a mask at the clinic, not requiring clinic staff to wear  
24   masks, not requiring clinic visitors to wear masks, not requiring clinic patients to wear masks  
25   (except for those with known or suspected COVID-19), posting information in the clinic about  
26   the alleged harms of mask wearing due to CO2 toxicity,<sup>60</sup> verbally counseling patients about the  
27   alleged harms of mask wearing, advising patients that the medical evidence does not support  
28   mask wearing, and recommending that patients view Ms. Clark’s YouTube video critical of  
29   mask wearing, Licensee actively discouraged patients from wearing masks, both at the clinic and  
30   in the greater community.  
31

32           In addition, the record persuasively establishes that Mrs. LaTulippe (his wife, clinic  
33   manager, and medical assistant) advised patients that masks do not work, directed patients to  
34   watch Ms. Clark’s YouTube video, and — at a minimum — suggested that patients remove their  
35   masks at the clinic. *See* Transcript I at 126-127, 141-142; Transcript II at 146-150, 155-156,  
36   244, 237-23; Transcript V at 170. Although the record falls short of establishing that Licensee  
37   *specifically directed* these communications between Ms. LaTulippe and clinic patients, a  
38   preponderance of credible evidence supports a finding that Licensee knew of and indorsed such  
39   communications and general practices. Additionally, as noted above, Licensee is the clinic’s  
40   physician. As such, his failure to wear a mask and his constant verbal denunciations of mask  
41   wearing encouraged his patients and his staff to not use masks. Consequently, when assessing  
42   whether Licensee’s practice of medicine posed an immediate danger to the public or a serious  
43   danger to the public health and safety, it is reasonable to consider not only Licensee’s own  
44   volitional conduct, but also staff conduct that he allowed and condoned.  
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<sup>60</sup> *See* Exhibit A6 at 4.

1                   *Conclusion*  
2

3           The phrases “immediate danger to the public” and “serious danger to the public” are not  
4 defined in either ORS Chapter 677 or ORS Chapter 183. The Board argues that putting others at  
5 risk of infection with a communicable disease and risk of death by failing to comply with  
6 COVID-19 protocols that are designed to protect healthcare providers and patients falls within  
7 those definitions, particularly while in the midst of an ongoing pandemic that has already killed  
8 more than 500,000 people in the United States. The Board’s argument is persuasive.  
9

10          Licensee is subject to and answerable to the laws, regulations, and orders issued under  
11 lawful authority in this state, as well as the Board, which is charged with the responsibility to  
12 protect the public from unprofessional conduct, to enforce the provisions of the Medical Practice  
13 Act, and to exercise general supervision over the practice of medicine. *See* ORS 677.015; ORS  
14 677.265(1)(c). When it comes to the practice of medicine in Oregon, the Board is the arm of the  
15 state charged with protecting its citizens against an epidemic of disease.  
16

17          Under ORS Chapters 183 and 677, the Board has the statutory authority to decide when a  
18 physician’s continued practice poses a serious and immediate danger to public health and safety,  
19 and to emergently suspend that physician’s license accordingly. *See* ORS 183.430(2); ORS  
20 677.205(3). Here, the Board correctly concluded that Licensee posed an immediate and serious  
21 danger to the public health and safety and exercised its discretion and authority by emergently  
22 suspending his license.  
23

24          In sum, the record persuasively establishes that Licensee’s refusal to wear a mask, his  
25 refusal to ensure that his staff wore masks, and his insistence on advising his patients to not wear  
26 masks endangered public health and safety by placing Licensee’s patients, his staff, and Licensee  
27 himself — plus all other individuals with whom they came in contact — at risk of infection of a  
28 highly communicable and deadly disease. Because of Licensee’s insistence that he will not alter  
29 his conduct no matter the outcome of this proceeding, the circumstances at the time of the  
30 issuance of this order<sup>61</sup> justify the continued suspension of his medical license. However, the  
31 serious and immediate danger posed by Licensee is related directly to the COVID-19 pandemic  
32 and, in Oregon, the declared state of emergency. Therefore, once Oregon’s current declared state  
33 of emergency is terminated, Licensee’s refusal to wear a mask, refusal to ensure his staff wears  
34 masks, and insistence on advising his patients not to wear masks, will no longer constitute a  
35 serious and immediate danger to the public, or to the public health and safety, under this order.<sup>62</sup>  
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45       <sup>61</sup> The now-relevant date.

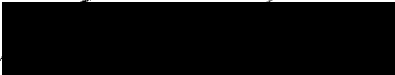
46       <sup>62</sup> An emergency suspension of a medical license is temporary under ORS 677.205(3); therefore, the Board sets forth  
the events that will trigger lifting of this order of emergency suspension.

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**ORDER**

The December 4, 2020 Order of Emergency Suspension of License and Notice of Opportunity for Hearing, ordering the immediate suspension of Steven Arthur LaTulippe's license to practice medicine in Oregon, is HEREBY CONFIRMED and ordered to remain in place until, under the authority of ORS 401.204, the state of emergency declared in response to COVID-19 is terminated by proclamation of the Governor of the State of Oregon, or by joint resolution of the Oregon Legislative Assembly.

So ORDERED this 6<sup>th</sup> day of May 2021.

  
Robert Cahn, MD, Vice Chair  
Oregon Medical Board

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**APPEAL**

Licensee may appeal this final order by filing a petition for review with the Oregon Court of Appeals within 60 days after it is served upon Licensee. *See* ORS 183.480 *et seq.*